



CITY OF SALFORD.

EDUCATION COMMITTEE.

SCHOOL HEALTH SERVICE.

REPORT

OF THE

SCHOOL MEDICAL OFFICER,

J. L. BURN, M.D., D.Hy., D.P.H.,

For the Year ended 31st December, 1951.



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Staff of the School Health Service

SCHOOL MEDICAL OFFICER	J. L. BURN, M.D., D.Hy., D.P.H.
SENIOR ASSISTANT SCHOOL MEDICAL OFFICER	J. L. BRADLEY, M.B., Ch.B., D.P.H. (until 31st March). D. E. JEREMIAH, M.B., B.S., D.T.M. & H., D.P.H. (Acting from 1st April).
PART-TIME ASSISTANT SCHOOL MEDICAL OFFICERS.	ANNE R. GRATTON, M.B., Ch.B. WINIFRIDE M. HAMILTON, M.R.C.S., L.R.C.P., D.P.H. KATHLEEN M. BOYES, M.B., Ch.B., D.P.H. MARIAN MAXWELL-REEKIE, M.B., Ch.B. B. HIRSH, M.D. EILEEN E. MCGUINNESS, M.B., Ch.B. MARJORIE LANDAU, M.B., B.S., M.R.C.S., L.R.C.P., D.C.H. J. G. WOOLHAM, M.D., Ch.B., D.P.H.
PART-TIME OCULIST	J. SCULLY, M.B., Ch.B., D.P.H., D.O.M.S.
PART-TIME ORTHOPTISTS... ..	RUTH M. LATIMER, D.B.O. KATHLEEN M. BALL, D.B.O.
SENIOR DENTAL OFFICER	L. H. POLLITT, L.D.S. (deceased August).
ASSISTANT DENTAL OFFICERS	AGNES M. PATERSON, L.D.S. A. FRANKENSTEINS, D.D.D., D.M.D.
PART-TIME DENTAL OFFICERS	BERYL LEVY, L.D.S. (resigned August). R. BRADBURY, L.D.S. E. BLASBERG, L.D.S.
PART-TIME DENTAL ANÆSTHETIST... ..	MARGARET O'GRADY, M.B., Ch.B.
CONSULTANT ORTHODONTIST... ..	J. I. MCCrackEN, L.D.S., V.U. (Manch.).
DENTAL ATTENDANTS	Mrs. E. HARRISON. Miss H. HALLIWELL. Miss M. T. MCCARTHY. Mrs. H. LEWIS. Mrs. E. READE.
ORAL HYGIENIST	Mrs. D. E. SWALES (resigned Oct.).
SPEECH THERAPISTS... ..	Miss GRETA M. GORDON, L.C.S.T. Miss MARGARET R. POTTS, L.C.S.T.
PHYSIOTHERAPIST	Mrs. N. RUDDICK, C.S.P.
PART-TIME CONSULTANT CHIROPODIST	FRANKLIN CHARLESWORTH, F.Ch.S.
PART-TIME ASSISTANT CHIROPODISTS	C. NEWMAN, M.Ch.S. Mrs. E. HARGRAVES, M.Ch.S.
AUDIOMETER TECHNICIAN	Miss J. MAHER.
SUPERINTENDENT OF HEALTH VISITORS AND NURSING STAFF...	Miss B. M. LANGTON, D.N. (London), S.R.N., S.C.M., H.V. Cert.
CHIEF CLERK	F. E. BIRTWISTLE, A.R.I.P.H.H.

SCHOOL HEALTH SERVICE REPORT.

TO THE CHAIRMAN AND MEMBERS OF THE EDUCATION COMMITTEE.

MR. CHAIRMAN, LADIES AND GENTLEMEN,

“ If we would rear a strong and virile race of people we require more children and healthier children as the foundation, to protect the child from disease, to build up its physique and provide it, as part of its education, with an understanding and practice of the laws of health.”

Sir George Newman.

I submit a report on the health of the Salford school child during 1951.

As it is not wise to judge the present and plan the future without consideration of the past, I have also compiled a history of the school health service in Salford, as far as records allow. It must be remembered that many historical records and reports in our possession were destroyed during the 1940 blitz ; in writing a history we have had to make bricks with little straw. Nevertheless, the material has been assembled and against this background of the story of the health of the Salford school child we can more clearly see a picture of the health of the child today and tomorrow.

In 1907 the local authority was given power to provide for the regular medical inspection of children in school. The primary object of the school medical service was to fit the child to receive the education provided for it by the state ; its ultimate objective was the health of the nation. Since 1907 the service has grown beyond recognition, but its aims have not altered. We still believe that to build a nation of healthy, happy people we must first aim for *the better care of the individual child.*

We use many methods to find and treat those children who need our special care. A high standard of *nutrition* is an important factor in the maintenance of health. Malnutrition in children is not, as is often thought, always associated with poverty. Various other factors are at work in this modern age—an unbalanced food intake due to ignorance of food values or lack of time of the working mother ; overcrowding of living accommodation ; inadequate rest and sleep ; lack of fresh air. I am happy to report that there has been a definite fall in the number of children classified during school medical inspections as having unsatisfactory nutrition.

The *attendance of parents at routine examination* of the earlier age groups is good, 94 per cent. of all those invited, but the parents' co-operation is not so marked with the older children. Indeed, only 18 per cent. of mothers of school-leavers attend their children's last school medical inspection. Perhaps there is a little too much routine medical inspection, though a system which

allows all children (whether they have excellent or subnormal health) to be examined regularly is of unique value. This must never be forgotten. The health of the Salford school child is improving, but children cannot afford, at the present time, to be without regular medical inspections.

During the year there was no relaxation of our campaign with regard to the control of *head lice infestation*. After many years of attempting its control, both by inspection and improved methods of treatment, we have come upon a hard nucleus of the population who appear to maintain infestation in the community. Persuasion, rather than prosecution, seems to be the best form of approach to this problem.

A more heartening fact is that the annual *scabies survey*, involving the examination of 10,000 children, brought to light not one infested case.

We were fortunate during the year in having the services of the *Mass Miniature Radiography Unit* placed at our disposal again. Many school-leavers and teachers wisely took advantage of this fine precautionary measure.

The better care of the individual child, which we are always striving to bring about, involves the efforts of family doctor, medical officer, school health visitor, medico-social worker, sanitary inspector—indeed all members of the health team, from the home help to the hospital staff, from the cooks, cleaners, caretakers in our clinics to the pædiatrician and pathologist. Particular effort has been made to *co-operate with the family doctor*, with whom we are closely allied in the fight for health, before referring a patient on his list for a consultant's opinion. This opinion, when received, is always sent back to him. Family doctors are regularly circularised with details of the specialists' sessions held on clinic premises, to which they are encouraged to send patients.

We maintain good *liaison with the hospitals*. We invite to our clinics children who otherwise would have to be seen by the already hard-pressed staff of out-patients' departments. Copies of the school medical records of children known to need in-patient treatment are sent to the hospitals concerned. In return we receive details of the child's condition on his discharge, and are enabled to follow-up those who need further observation at home. This is a valuable exchange of information which, however, could be improved by its wider application.

May I take this opportunity of thanking the many consultants who, when approached, have given me the benefit of their advice in respect of individual children. This advice is of great value, especially when decisions have to be made regarding the special educational treatment of the child concerned.

One of the "highlights" of our health education programme has been the inauguration of the *Children's Health Club*, run through the medium of the local paper.

We find that this weekly contact with the children is a useful means of broadcasting simple health education to those who would readily accept it—youngsters between the ages of 5 and 15.

A badge—designed by an amateur artist on the staff of the health department, depicts St. George and the Dragon, and represents the fight against the dragon of disease and ill-health. The motto is “We fight for health.”



We have devised the following health rules for our members to follow. They are :—

1. Wash your hands before meals and after using the toilet ;
2. Always keep yourself as clean as possible ;
3. Clean your teeth thoroughly at least once every day ;
4. Use a handkerchief whenever you cough or sneeze ;
5. Have a good night's sleep every night ;
6. Be kind to others and try to greet people with a smile ;
7. Try to prevent accidents on the roads, at school and at home ;
8. Enjoy yourself in work and play.

Under the authorship of “Uncle John,” a full programme has been drawn up, which includes articles, competitions and film shows. Jokes and odd facts which children readily assimilate are printed.

Within the scope of the club's health education aims we include emphasis on home safety and try to encourage the children to take such simple precautions as putting away their play things when they have finished with them. We try also to stress the spirit of service by urging children to help their less fortunate schoolmates, particularly the handicapped children for whom we always give a big Christmas party.

In brief, the club sets out to capture the children's imagination and to present the art of healthy living in an attractive light.

Other interesting developments are described later in the report, one of which is the opening of the new *open-air school*, which provides a mark on the credit side of the balance. The debit side, too, has something to show. There is hardly a word in this report on the inadequacy of our school buildings—yet there are many buildings in which it is difficult to teach a healthy way of life. Health Education should be taught not only by precept but by practice.

This report is the work of many hands, although as School Medical Officer, I am responsible for the report as a whole. I am indebted to the following, not only for their accounts of the year's work but, more important, for their contribution throughout the year to the school health service in action :—

Dr. D. E. Jeremiah	...	...	...	...	Acting Senior Assistant School Medical Officer.
Mrs. F. Cavanagh	...	...	...	...	Consultant Ear, Nose and Throat Specialist.
Dr. J. Scully	...	...	...	...	Consultant Oculist.
Dr. A. J. Gill	...	...	...	...	Consultant Skin Specialist.
Dr. R. I. Mackay	...	...	...	...	Consultant Pædiatrician.

Mr. Franklin Charlesworth	...	...	...	...	Consultant Chiropodist.
Miss G. M. Gordon...	...	...	...	...	Speech Therapist.
Miss B. M. Langton...	...	...	...	...	Superintendent Health Visitor.
Miss P. K. Fogg	...	...	...	...	Physiotherapist.
Miss B. Chadwick	...	...	...	...	Almoner.
Mr. E. Blasberg...	...	...	...	...	Dental Officer.
Mr. J. C. Starkey	...	...	...	...	Chief Sanitary Inspector.
Miss M. D. Adamson	...	...	...	...	Psychiatric Social Worker.

My thanks are specially due to those members of the medical, nursing, and administrative staffs who are not mentioned by name but by whose effective efforts the school health service is better able to help our children.

I am particularly grateful for the ready co-operation of the Director of Education (F. A. J. Rivett, Esq., M.Sc.) and the teaching and administrative staffs of the Education Department, and for the help given by Miss A. Ashworth, Mr. A. Tordoff, Miss A. Sparrow, Mrs. E. Raby, Mrs. G. Plunkett, Miss L. W. P. Bell and Mr. T. Parker in the compilation of the sections of this report which deal with their work.

The teacher is a close colleague in our efforts towards better health for the children. We have a common aim—to develop a sound mind in a sound body. Throughout the year we have worked together in a happy and, I believe, an effective way.

School Nursing.

WORK IN SCHOOLS.

The work of nursing staff may be considered under the following headings :—

1. Personal hygiene.
2. Assessment and supervision of general health.
3. Assistance at medical examinations.
4. Health education.
5. Home visiting.

(1) PERSONAL HYGIENE.

Each child attending school has been examined by a health visitor at least once every term with particular reference to cleanliness and head infestation.

The infestation rate for the year—16·21 per cent. is only very slightly lower than that for 1950 which was 17 per cent. Although one would hope for a more marked reduction, it must be remembered that the standard governing the assessment of infestation in Salford is very high, viz., a child found with one nit only once in the year is deemed to be infested. Such a child exercises the same influence on the infestation rate as the child heavily infested with nits and/or vermin every term. As is shown below almost half the children concerned were infested once only during the year. In all these cases the degree of infestation was only slight.

Total number of individual children found to be infested = 4,347, of these :—

Children infested once only during the year	= 2,045	} 4,347
Children infested twice during the year	= 1,205	
Children infested three times or more during the year	= 1,097	

Compulsory Cleansing. After due warning had been given to the parents concerned, the heads of 189 children were cleansed by a hygiene attendant. Of these, 46 children became re-infested and had to be de-loused every term.

Nursery Schools. A more marked reduction took place in the infestation rate among nursery school children—from 23 per cent. in 1950 to 18·85 per cent. in 1951. As most of the mothers in these cases go out to work and come home in the evening when the children are tired and fretful and ready for bed, it is difficult to get them to exercise regular supervision and care of the hair.

In many of the cases of frequent head re-infestation, the childrens' general standard of hygiene is low, bodily cleanliness leaves much to be desired and clothing is often ragged and dirty.

(2) ASSESSMENT AND SUPERVISION OF GENERAL HEALTH.

Rapid Surveys. This aspect of the work which was described fully in last year's report, has been developed to include the full examination by a health visitor of every child in almost all schools. The assistance given by hygiene attendants in this sphere has been of great value and has saved much of the more highly qualified workers' time.

This comparatively new aspect of school nursing has shown interesting developments but is still only in the experimental stage. The surveys seek to



Rapid Survey in School

supervise the health of the children frequently, referring children who need expert diagnosis or treatment to the appropriate clinic. This provides an opportunity for detecting the beginnings of disease, and provides especially the opportunity for the nurse and teacher together to confer on these children who may be suffering from lack of energy, lack of appetite, lack of joy and health. The early symptoms of disease are often vague. They may be observed only by the teacher who sees the child every day, and who has the opportunity of noticing some change in the behaviour, the attitude or the temperament of the child. It is also a very useful screen for serious conditions like discharging ears to be discovered. A few parents do not bother.

It is right that a health visitor should frequently visit the school, not merely as a nit nurse, but as someone who can help in better child welfare.

The findings at rapid surveys vary according to the type of school and area, the most important being the high incidence of unsuitable and/or defective footwear, with its resultant train of minor foot defects. More important are the potentialities for permanent foot disabilities, which may show serious results in adult life.

Footwear provided by the Education Committee is of good quality, and it has been noticed in foot surveys in the "poorer" schools that the children are wearing shoes of a superior kind.

With consolidation and expansion of the medical and educational aspect of this work, rapid surveys may rightly claim the central place in the School Health Visitor's work in the future.

During the year almost 14,000 children were examined by this method. One thousand of these were referred to the assistant medical officer for treatment or observation. The general condition of 25 per cent. of the children referred was unsatisfactory ; 13 per cent. had diseases of the ear, nose and throat ; 9 per cent. had skin disorders ; 5 per cent. had defective vision ; 5 per cent. had otorrhœa ; 5 per cent. had poor posture ; 4 per cent. had some defect of speech ; 3 per cent. needed chiropody treatment. It was interesting to note that 27 per cent. of the children had no handkerchief.

Infectious Disease. Nine schools were specially visited during the year with regard to outbreaks of infectious disease, and a total of 223 children examined.

Vision Testing. Vision testing was carried out among all eight-year-old children, in addition to those cases where the school teacher or the health visitor suspected defective vision.

Treatment of Minor Ailments. The treatment of minor ailments was carried out daily on school premises at six schools including the new Claremont Open-Air School, opened in September. The clinic held at St. Ambrose School was discontinued when the new Langworthy Centre was opened in November. This was in addition to the minor ailments sessions held on clinic premises.

An important feature of child welfare in schools is the "on-the-spot" clinic, actually at the school, which emphasises the idea of "bringing the clinic to the child, rather than the child to the clinic." Obvious advantages are that the child will not have to run the risk of crossing dangerous roads ; and also minor ailments will be able to be dealt with easily and immediately, whereas the child might not be bothered to go to an outside clinic. Another advantage of the school clinic is that there is no wastage of time in travelling.

The story has often been told of the two young boys who after visiting the minor ailments clinic in Regent Road, got lost, played truant from school, and finding a billiards table in the basement of the building started to play. This would not have happened if there had been a clinic at the school.

A mobile clinic has been approved in principle, and it is hoped that before long it will help in this scheme of a clinic on school premises rather than risking what may be a dangerous journey to the clinic, in crossing main roads.

(3) SCHOOL MEDICAL INSPECTIONS.

School medical inspections were attended by health visitors who carried out any necessary preliminary measures and assisted the School Medical Officers carrying out examinations.

WORK IN SCHOOLS (EXCLUDING TREATMENT OF MINOR AILMENTS).

	Health Visitors.	Clinic Nurses.	Total.
Medical inspection sessions	684	4	688
Hygiene inspection sessions	872	15	887
Hygiene re-inspection sessions	259	6	265
Special visits to schools	405	33	438
Special visits to nursery schools	399	—	399
Vision testing sessions	186	30	216
Rapid Survey sessions	366	6	372
Immunisation sessions	10	147	157
Miscellaneous sessions (Camp : B.C.G. ; Weighing and Measuring ; Infectious Disease, etc.)	36	—	36
TOTAL—1951	3,217	241	3,458
TOTAL—1950	(2,842)	(398)	(3,240)

(4) DOMICILIARY WORK.

Home Visiting was carried out :—

- in order to ensure that medical advice was properly understood and carried out ;
- to advise regarding cleanliness, clothing, and verminous infestation ;
- to carry out special investigations relating to home circumstances and family history in all cases of handicapped children ;
- to investigate absenteeism from various clinics.

	Health Visitors.	Clinic Nurses.	Total.
Medical follow-up visits	761	208	968
Cleanliness follow-up visits	634	1	635
Special visits	—	11	11
TOTAL—1951	1,395	219	1,614
TOTAL—1950	(1,033)	(528)	(1,538)

Posters and leaflets were distributed to schools and school clinics, via the school nurses.

The film-strip on the School Health Service was found to be very useful, and several talks to parent-teachers' groups were given.

The aspects of home and road safety were emphasised by the distribution of various painting cards.

(5) HEALTH EDUCATION IN SCHOOLS.

The opportunity to offer their help in the field of health education in schools presents itself whenever a health visitor enters a school for the purpose of conducting an inspection or survey.

Up to the present, three health visitors have been able to make health teaching an integral part of their school health work. These educational visits have been paid with varying regularity owing to the fact that the staffing of clinics receives absolute priority over other types of work. One of the three health visitors has been able to pay only occasional visits. The other two have tried to pay weekly or fortnightly visits and to follow a syllabus.

So far, the regular lessons have been confined to senior girls—mainly those in their final year. Mostly one period was at the health visitor's disposal, but during a parentcraft course in the summer term the second period of the afternoon was added in order to give the pupils opportunity for practical work.

In addition to their lessons, a few short talks (15 minutes) were given to mixed classes of younger age groups at the time, and in connection with hygiene inspections.

Courses given have been :—

- (i) Personal Health.
- (ii) Parentcraft.
- (iii) The National Health Service.

COURSE I—PERSONAL HEALTH.

This course was complimentary to the health teaching given by the class teacher. Its aims were :—

- (a) To foster interest in personal health amongst the pupils.
- (b) To encourage an attitude of responsibility for their own health and happiness.
- (c) To help the pupils to an understanding of the body and its various functions.
- (d) To teach the principles of healthy living. Two methods have been used.

1. *The Physiological Approach.* This is built on the natural curiosity of the growing girl about her own body and its functions, but it also exploits—and thereby modifies—the child's morbid interest in disease. The themes of such a course are life processes such as the circulation of the blood, digestion, posture, sleep, etc. From the understanding of these are derived the essential conditions of health.

2. *The "Hygiene" Approach.* This is more suitable for young pupils. The fundamental habits of a healthy life are linked with the other activities of the child. It includes the care of skin, hair and teeth and stresses such important rules of health as sleep, fresh air, good food.

COURSE II—PARENTCRAFT COURSE.

The aims of this course are along the same lines.

1. To foster interest in babies and young children, and to help the girls to look forward to their own future as wives and mothers.

2. To encourage an attitude of family responsibility for the health and happiness of children.

3. To help the pupils to an understanding of the development and needs of babies.

4. To foster initiative and the art of improvisation.

5. To give the pupils confidence through practice. In one school this course was held during the period preceding "Education Week." All the equipment required for the care of a baby was made by the pupils themselves at very little cost. They staged their exhibition with great pride, and the younger pupils as well as the people from the neighbourhood showed a great deal of interest. Practical demonstration in this instance included the bathing, dressing and handling of the baby sister of one of the pupils.

COURSE III—THE NATIONAL HEALTH SERVICE.

This was a course of 12 lessons based on the two previous courses. The chief points were once more—interest, personal responsibility, self-reliance and consideration for others. An additional aim was to give a sense of community to the pupils.

The course was constantly linked up with other studies of the school curriculum given by the school teacher.

1. *History*—in unfolding the historical background of public health and care of the sick.

2. *Social Studies*—seeing the National Health Service as a part of the wider scheme for social welfare.

3. *Citizenship*—showing the true relationship of government and people as it affects public and personal health. Love of their country is there, but often only as emotion, unrelated to practice. It was interesting to note how well the children were able to grasp the economic aspect of the National Health Service Act when it had been brought into contact with their personal lives. Taxes and treatment, rates and services, contributions and benefits—these are related facts that are more easily understood by children who have not been sheltered from the economic facts of life. Yet whether they have learnt from life that which they understand for a moment is highly doubtful, especially those children who have to live in an atmosphere of apathy and scrounging.

SYLLABUS FOR COURSE IN PARENTCRAFT FOR SENIOR GIRLS.

LESSON I. *Introduction.*

Reasons for studying parentcraft—parents' responsibility for health and happiness of the child—standards of child nurture—the effect of environment—the value of training in giving knowledge and confidence—the need for unselfish love.

LESSON II. *The Normal Infant.*

Elementary facts about a new baby : condition, appearance, capabilities, limitation. Baby's fundamental needs : love, security, protection, warmth, food, sleep—a survey ; handling a new baby.

LESSON III. *Baby's Clothing.*

The need for warmth—guiding principles for health clothing—value of different materials—freedom and comfort—some good patterns—planning a layette—making and saving—wise shopping.

LESSON IV. *Feeding a Young Baby.*

Need for food : growth, energy, satisfaction—natural feeding : human babies and animal babies—reasons for breast feeding—conditions of success—the importance of confidence—vitamins—reasons for artificial feeding—its dangers and disadvantages—care of equipment—supervision.

LESSON V. *Weaning Time.*

The right moment—teething—gradual introduction of solid food—preparing baby meals—some suitable foods for young babies—more about vitamins—preventing fads.

LESSON VI. *Baby's Toilet.*

The need for cleanliness : protection—baby's skin—function of the skin (elementary)—the care of baby's skin ; “topping and tailing,” changing napkins, baby's bath. Preparation and technique of bath—improvising essential equipment—importance of clean clothing and home.

LESSON VII. *Baby's Health—how to maintain it.*

- (a) The need for sleep : amount of sleep—sleep and growth—putting baby to bed—baby's cot and pram.
- (b) Fresh air and sunshine—effect on health—ventilation.
- (c) Routine and a quiet life—the value of habit, laying foundations of good habits—importance of security—avoiding rigidity—mutual adaptation.

LESSON VIII. *Baby's Health—prevention of illness.*

Normal development—signs of health—muscle tone—preventing infection and digestive upsets—preventing rickets. Vaccination and immunisation—regular examination by a doctor.

LESSON IX. *The Sick Baby at Home.*

Signs of illness—need for observation—when to call the doctor—special needs of the sick baby—simple nursing points. Some babies ailments—danger of doing without medical advice—prevention better than cure.

LESSON X. *Protecting Baby from Accidents.*

Safety in the home—protecting baby from himself—danger of careless adults—how accidents happen—avoiding over-anxiousness—safety and confidence.

LESSON XI. *The Help from the State.*

Financial help : maternity benefits, family allowance, vitamin supplements, tax allowance.

The Health Service : The Local Health Authority—The Midwife Ante-Natal Clinic, Infant Welfare Centre, Medical Officer and Health Visitors, Home Help, free protection against smallpox and diphtheria. The family doctor—the district nurse—hospital.

The parents' responsibility—the family in the Welfare State.

Practical activities : budget for the layette, making a baby gown pattern, changing and bathing a baby, preparation of improvised toilet box, making the cot, care of bottle feeding equipment, making a baby scrap book.

CONDITIONS FOR SUCCESSFUL HEALTH TEACHING.

The aims and fundamental principles of health education in schools have been stated at some length, for it is vital to be quite clear about them, otherwise they may get lost in the difficulties and frustrations that beset the visiting health teacher. Whether one is able to follow an ideal plan or whether one must struggle with adverse conditions, the aims of health education remain the same. The schemes themselves need to be flexible and allow for maximum adaptation. There are, however, conditions essential for the success of this work. Two of these are of primary importance.

1. Complete mutual trust and respect between school teacher and health visitor.
2. A good relationship between pupils and health visitor that will lead to their willing acceptance of her leadership in this sphere.

SECONDARY CONDITIONS FOR SUCCESS.

1. *Regularity.* The necessary time must be at her disposal and this work can never properly develop until precedence is given over other aspects of routine health visiting duties. It should be remembered that health visitors are primarily intended to be health teachers.

2. *The link with social welfare.* It is because she is the link between school and home that the health visitor can make her special contribution. She knows the children at school and in their own social setting, and she is able to adapt her teaching through her constant contact with reality. This value would be lost if the health visitor were appointed as a full-time health teacher and gave up her social work.

3. *Concentration.* Every school that is entered by the school health visitor should be regarded as a sphere of health education to her. This reduces the number of schools which she can effectively visit to two or three at the most. It is vital that health education should be spread over several age groups in one school by linking it up with routine examinations and hygiene inspections. Responsibility for too many schools dissipates the health visitor's energy.

4. *Assistance and Delegation.* Help in school is needed with school medical sessions, hygiene inspections and rapid surveys. The time saving is not the only factor—it affects also the vital factor of prestige with teachers and pupils. If many hours are spent in looking at children's heads only an outstanding personality can rescue sufficient prestige to be acceptable as a teacher. There are insufficient hygiene attendants employed to allow for any real development in this field at present.

5. *Access to suitable visual aids and help with their preparation.* Visual aids should stimulate the imagination of the pupils. They need not be elaborate and often are best when simple and hand-made. Until the health visitor obtains some help in this direction, she will largely have to carry on without visual aids apart from the use of blackboard and posters.

6. *Co-operation with the Education Department.* The health visitor is aware of her need for guidance in the sphere of school education. She enters the school as nurse and social worker, willing to make a special but limited contribution to the children's education. For this she needs the full consent and approval of the Education Department, and, if possible, personal contact with members of their staff.

If the health visitor knows that she has something to give she also knows well that she has much to learn. The co-operation of the teachers in the schools where health teaching has been attempted has been very much appreciated.

Report on the Work of the Ear, Nose and Throat Clinic during 1951.

The Ear, Nose and Throat Clinic has continued its work. There have been difficulties in seeing patients as quickly as we could wish because we lost the services of Dr. F. D. Martinson. The Regional Hospital Board did not appoint anyone in his place and it was not until we appointed Dr. I. M. Leach as Assistant to the Ear, Nose and Throat Department in August that we were able to increase the amount of work done.

PROCEDURE.

The consultant sees all new cases at the first visit. In some cases it is obvious at this first examination that tonsils and adenoids operation is necessary and the child's name is then added to the waiting list for admission to Hope Hospital. This child may not need to come back to the Clinic until he is re-examined three weeks after operation.

Other children who are listed for operation may need treatment in the meantime in order to maintain the health in as good a condition as possible until operation is performed. These cases may be given treatment at home or they may be asked to attend the School Clinic—for dressings to the ear or for nasal hygiene. Such children will probably be seen at two monthly intervals until operation and these cases can be kept under observation by the Assistant to the Ear, Nose and Throat Department. If the child's health is deteriorating—or if for any reason Dr. Leach is not satisfied with the patient's condition—the child is brought along to the consultant for a further opinion as we hold our Clinic together on Tuesday afternoon and are able to discuss any case.

A third group of children (when seen by the consultant at the first visit) may not need operation but may require treatment along other lines. Some are given a course of special breathing exercises designed in the form of games or competitions—which will encourage firm closure of the mouth and satisfactory nasal breathing.

Some are taught at the Clinic to douche their noses so that secretions are not allowed to stagnate in the nose. In this way the mucous membrane is cleared of accumulated discharge and is aerated and given a chance to recover its function.

Some are given a *holiday* at a Convalescent Home. Others are sent to an Open Air School. Some who have had no cod liver oil for a year or two are given adequate vitamins again—perhaps in another form as many children seem to rebel against cod liver oil as they grow older.

Some have catarrhal deafness which needs constant observation—especially in a Salford climate. These cases have their hearing checked by Audiometer Test so that we have an accurate record. They are treated and observed and when clinical improvement seems satisfactory a further Audiometer Test is done. If this confirms the clinical finding treatment may be stopped—or reduced—but the parent is warned to watch carefully for any falling off in hearing and to report at once to the Clinic if this occurs.

If the Audiometer Test still shows some impairment it is useful to show this result to the parent so that treatment will be continued when to all ordinary appearances it seems unnecessary.

Some children have *acute suppurative otitis media* when first seen. In these cases we use every means we have to heal the ear in two to three weeks. In most cases we achieve this quite readily by dressing the ear daily. In some cases further help is given by treating the nasal catarrh at the same time. In a few it is not possible to obtain a healed drum with out-patient treatment. In these cases if there is no improvement in two weeks we arrange for in-patient treatment which is usually successful. It cannot be stressed too often or too forcibly that every acutely suppurating ear must be cured within three to four weeks—and by cured we mean a healed drum and normal hearing. Neglected “acute” ears will become “chronic” ears and unfortunately we still have many cases of chronic suppuration in the ears.

NURSING DIFFICULTIES.

These are the most difficult and the most time-consuming cases we encounter. When we have satisfactory working conditions for the nurses—that is a room with a portable lamp and a head mirror for the nurse—and above all when we have nurses who will learn the details of cleansing an ear adequately—and yet painlessly—our results are improved.

Last year, to facilitate this, we raised the status of one of our nurses. This nurse has worked in an Ear, Nose and Throat Hospital ; she is therefore skilful in her dressings and, most important of all, she is interested in these cases. She now sees at least once a week all the ear cases which are difficult to dress or are in need of more experienced care. As a result of this we have been able to obtain a greater proportion of dry ears than would have been possible otherwise.

MODERN TREATMENTS.

We have been ready to accept new developments in the therapeutic field. Several years ago we were pleased to report improvements in certain selected cases of ear suppuration after using a Penicillin-sulphathiazole powder. A few years later we found that Streptomycin if used with care—and for only seven to ten days at a time—caused an improvement in some ears which resisted other lines of treatment.

Now we are using Chloromycetin in a few ears. This preparation is extremely expensive and is not used except in special circumstances. In those cases where it is thought desirable to use it we have written to the family doctor concerned and have asked if he would give the patient the prescription. The parent has then brought the preparation to the nurse who is dressing the ear. We are pleased to report that all the Practitioners concerned have been willing to co-operate with us.

The severely deafened child is extremely well catered for in Salford where the *class for the partially deaf* continues successfully. We also are able to provide lip reading classes in the later afternoon for children who are not deaf enough to require removal from a normal school but who yet need extra help.

We could help many children more quickly if minor procedures could be done on out-patients. For instance, antral lavages in children over five or six can be done with no more discomfort than is involved by a visit to the Dentist. These sinusitis cases could then be dealt with almost at once. Nowadays the child has to wait for a bed in Hope Hospital—and may be waiting for months. There are small ear operations such as myringotomy, removal of aural polyp and incision of boils, which could be dealt with similarly.

Further help in the Physiotherapy Department is increasing the benefit to many children. There is a great need for speeding up treatment by speech therapy. It is good to know that a second Speech Therapist has recently been appointed. When there is a long waiting list for these cases the children become fixed in their bad habits and grow more self-conscious of their defects, with the result that treatment is then more difficult and more prolonged.

The Pre-Tonsillectomy Clinic.

Many experts in the ear, nose, and throat field consider that tonsillectomy is hardly ever an urgent operation. Full clinical investigation should be made, prior dental treatment carried out and examination, especially of the sinuses, be done before a final decision regarding the necessity for tonsillectomy is made. In carefully selected cases, however, it is agreed that “there is no single operation in children’s medicine more successful or one which shows such dramatic results as tonsillectomy.”

During 1951, 395 medical examinations were made by the pædiatrician at our Pre-Tonsillectomy Clinic. These sessions are held in a room which is adjacent to the clinic of the consultant ear, nose and throat specialist, a most useful arrangement when a second opinion is necessary.

Many of the children were reviewed at intervals during the year, and nine names were removed from the list of children awaiting operation.

Consultant Skin Clinic.

This clinic is held once weekly at Regent Road on Thursdays at 2-30 p.m., and provides facilities for the diagnosis and treatment of skin disorders in Salford school children.

The overwhelming majority of cases can be treated fairly simply and easily as out-patients without loss of valuable time at school. There remains however, the cases for which hospitalisation is needed, and these include the perennial problem of the allergic child with severe infantile eczema often co-existent with asthma. The mother of a large family which includes a child with this distressing affliction is often brought near to breakdown by continued loss of sleep and worry over the child’s condition. Severe cases in children such as these are benefited enormously by periodic short stays away from the family and in hospital.

Occasional cases of obscure or doubtful aetiology also are seen, and for these also hospitalisation, with its facilities for full observation and investigation, is preferable.

I am glad to report that there is satisfactory co-operation between clinic and hospital, and beds are available at Hope Hospital for these cases.

During the year under review there has been a continued decline in the numbers seen of cases of scabies, impetigo, and septic cuts and abrasions, and I am quite sure that the main factor for contributing to this is the more efficient and systematic treatment being given both at clinics and by the family doctors.

The incidence of tinea of the scalp and of the smooth skin among school children in Salford is variable, and on the whole is not a considerable factor in causing loss of school time. Arrangements are made for each case of tinea of the scalp sent to the Consultant Skin Clinic, to be cultured, and the causative fungus typed and classified, so that according to type appropriate treatment may be given.

The great majority of cases seen are of the animal ringworm type (*M. canis*, etc.) and X-ray epilation is not essential in these cases.

The incidence of tinea of the smooth skin is fairly high, but its treatment is not difficult and presents few problems.

The incidence of common warts and of molluscum contagiosum remains high, and I would again urge the advisability of referring children as early as possible before these lesions have multiplied and increased the time required for treatment.

There has been a welcome decrease in the number of penicillin sensitization symptoms seen during the past twelve months.

During the year under review attendances numbered 1,160, including 28 cases of tinea of the scalp, 20 of tinea of the smooth skin, and 107 cases of impetigo.

There is undoubtedly scope for further development in the future.

Foot Health Clinic.

The modern trend in the health service is to accentuate the fundamental importance of preventive medicine. This has brought a realisation of the value of mass inspections, surveys, etc. There is often a tendency in the lay mind to regard this as a health service on the wholesale principle, but in effect it is actually the reverse. By a wise and careful systematic examination of children, as for instance takes place in rapid surveys by health visitors, mass radiography, dental inspections and foot surveys, defects are frequently detected whilst they are of a minor character and easily corrected. Were these conditions allowed to go undetected they may not be noted until the symptoms were marked and the condition had reached a chronic stage, where correction or a complete cure would be difficult or even impossible. It will, therefore, be seen that whilst the inspections or investigations are organised in the mass, prompt and adequate treatment of the individual is achieved. Once some defect has been noted the child is directed to the appropriate clinic. In the case of the Foot Surveys, the children are directed to the foot health clinic for the treatment of any minor defects.

Investigation over many years has brought to light some interesting facts, *e.g.*, surveys of children's feet carried out in 1951 showed that from a total of 1,338 children examined, the following percentages of gross defects were recorded :—

Long arch weakness	3.7%
Hallux Valgus	2.3%
Defects of lesser toes	3.7%

In addition it should be noted that there were many cases with slight defects such as :—

Long arch weakness	13.8%
Hallux Valgus	4.6%
Defects of lesser toes	6.9%

Therefore, the fact emerges that defects of some kind or other were noted in about 35% of children examined although it must be conceded that 25% were of a very minor character, and under reasonable conditions, proper fitting shoes and hose would in the main be self correcting. Of the balance of defects we have a substantial number, some 10%, in which prompt treatment is essential if permanent weakness or deformity in the adult is to be prevented. Mobile pronated feet if not corrected may result in serious postural defects, round shoulders, congestion of chest, slouching gait, etc. A contracted toe easily straightened by simple splinting in the case of the child can, if not treated, become a permanent hammer toe resulting in much misery and serious incapacitation. Neglected adolescent hallux valgus may find the adult with an unsightly gross deformity of the hallux and a painful bunion.

Another factor which is frequently overlooked is that the neglect of one defect may result in another, *e.g.*, it is now well established that a great proportion of cases of hallux valgus are the result of the valgus deviation of the forefoot when walking in the case of pronated feet, whilst hammer toe may result from the forcing back of the second toe by the great toe in cases of gross hallux valgus.

The value of special surveys cannot be over-estimated, as may be instanced in the case of a school where cases of verrucae plantaris were reported. A survey of the school revealed 14 cases which were immediately given treatment. As a result of this investigation and prompt action an undoubted epidemic of verrucae throughout the school was checked and this may well have prevented a serious interference with the educational programme.

The examination of children's feet over many years has proved the adverse effect on children's feet of unsuitable and ill-fitting footwear. During the recent survey, quoted above, no less than 28% of the children were found to have shoes at least one size too small. Of these 11% were wearing shoes two sizes, or more, too small.

The primary reason for the prevalence of short shoes is that few shoe retailers appear to stock children's shoes in more than one fitting, and as the greater proportion of children are found to require the broad fitting shoe,

it is these shoes which are usually stocked. Therefore, when fitting a slim foot a shoe of the correct length appears much too big, owing to the fullness of the fitting. (1) If the foot has not been previously measured and the shoes



Fig. 1. Showing the Broad and Narrow Foot Types.

are fitted merely by trial and error, the tendency is to try on a less and less size until the foot appears to fill the shoe adequately. Unfortunately, by then the great toe is jammed up against the end of the toe box and the child is wearing a shoe hopelessly short. (2) Permanent injury to the nail and toe joint



Fig. 2. Hallux Flexus with Painful Bursar resulting from Faulty Fitting of Pro-Cavus Feet. Boy age 11 years.

is frequently the result of this form of faulty fitting. Not only do we find that many of the shoes are fitted short and bear no relation to the foot type of the child but they are frequently very unsuitable in design, often based on freak adult styles, i.e., sling backs, peep-toe, wedge heels. (3a) (3b) (4) The shoe should follow the contours of the natural foot and the fitting should be related to the width of the foot. As we encounter both slim and broad feet in the child, shoes should be stocked in at least three fittings so that the correct fitting, as well as the correct size is available. It is the correlation of these three factors—size, type and fitting, of footwear—that seems to be the stumbling block of the shoe retailer. It must, however, be appreciated that the shoe retailer cannot afford to keep considerable capital locked up in

sizes and fittings not frequently in demand, but a skeleton range of these would probably meet the case. Enquiry among shoe retailers has brought



Fig. 3a. Unsuitable shoes of adult type much too short and giving no support. Note Points of Pressure.

the complaint that shoes at prices suited to the lower income groups are not available on good lasts and in a variety of fittings. This is a perplexing problem when one endeavours to encourage correct shoe fitting in a district where



Fig. 3b. Permanent deformity of the toe resulting in the wearing of shoes as in Fig. 3a.

incomes are limited. Another factor is the scarcity of larger sizes in children's shoes in the lower price range, the feet of the modern child are indeed getting bigger (7's and 8's are not uncommon and size 6 is quite a common size in the 11-13 age group). A further disturbing problem is that many children in this age group tend to dictate the type of shoes they prefer to wear, and which are, unfortunately of the freak styles previously referred to.

Much may be done to alleviate this situation if liaison between the Health Department and the shoe retailer is established. Steps have already been taken and a meeting arranged by the Medical Officer of Health produced a ready response.



Fig. 4. Child age 12 years wearing parents cast off shoes.

SUMMARY.

To summarize we may conclude that careful and systematic surveys and foot inspections are of the utmost importance. Ill-fitting shoes are responsible for many foot defects and no effort should be spared to deal with the situation. Whilst clinical experience over many years has proved that correction of many of the minor defects can be achieved by simple methods, co-operation of the parent with the shoe retailer is essential, as shoes of the correct size and fit are *vital to successful treatment*.

School Dental Service.

During the year the shortage of dental officers which has resulted in a lack of regular and frequent school inspections and consequent conservative treatment, has caused the demand for extractions to rise to tremendous proportions—many being acute cases. However unfortunate this position was, it had to be faced and the relief of a child's toothache was given priority.

GENERAL ANÆSTHETIC. The great majority of extractions were performed under general anæsthesia administered by consultant anæsthetists. This has been found the most satisfactory method for extraction both from patients' and operators' point of view. The demands on this service have been very heavy especially at Murray Street Clinic, which had been closed for twelve months. An extra anæsthetic session at this Clinic has done something towards reducing the waiting list, and given an opportunity for the speedy treatment of acute cases. The demand, however, is still heavy.

Regent Road and Police Street Clinics have dealt with their "casuals" satisfactorily, no doubt due to the fact that regular school inspections have been carried out at these clinics. During the year, vinyl ether has been largely used as an adjunct to gas and oxygen anæsthesia by the anæsthetist, with excellent results, giving a pleasant and speedy recovery. Two thousand nine hundred and twenty-eight anæsthetics were administered, 10,288 teeth extracted, 8,908 being deciduous.

Penicillin injections for those cases in which there was a danger of infection spreading were made available, saving the child visits to distant hospitals, and giving quick and speedy results.

CONSERVATION. Although inspections and routine *conservative treatment* has had to take second place to the treatment of emergency cases, 5,379 teeth have been filled, 1,758 of these being fillings in deciduous teeth. At the same time, improvements in conservation technique and materials were introduced in the clinics.

The increasing use of local anæsthetics for fillings has taken a great deal of the fear out of the conservative treatment, and the co-operation obtained from the children even during long and intricate fillings has been remarkable. The fear of fillings has given way to a healthy interest in their teeth, and the process of filling them. It has been particularly gratifying to see the high attendance figures obtained during the school holidays.

ORTHODONTIC SERVICE. This service has grown steadily throughout the year. A great deal of satisfying work has been done in the correction of faulty occlusion often with marked improvement of the child's appearance.

Later in the year a second orthodontic consultant was appointed. This has resulted in a greatly reduced waiting list for treatment.

Orthodontics is a highly specialised branch of dentistry and we are indeed fortunate to be able to provide these consultant services for the children of Salford.

ORAL HYGIENE. During the year the services of an oral hygienist have been available to scale and clean the teeth of children referred by the Dental Officers. Not the least important part of her work has been to teach the children the proper use of the toothbrush and instil a pride in a clean and healthy mouth.



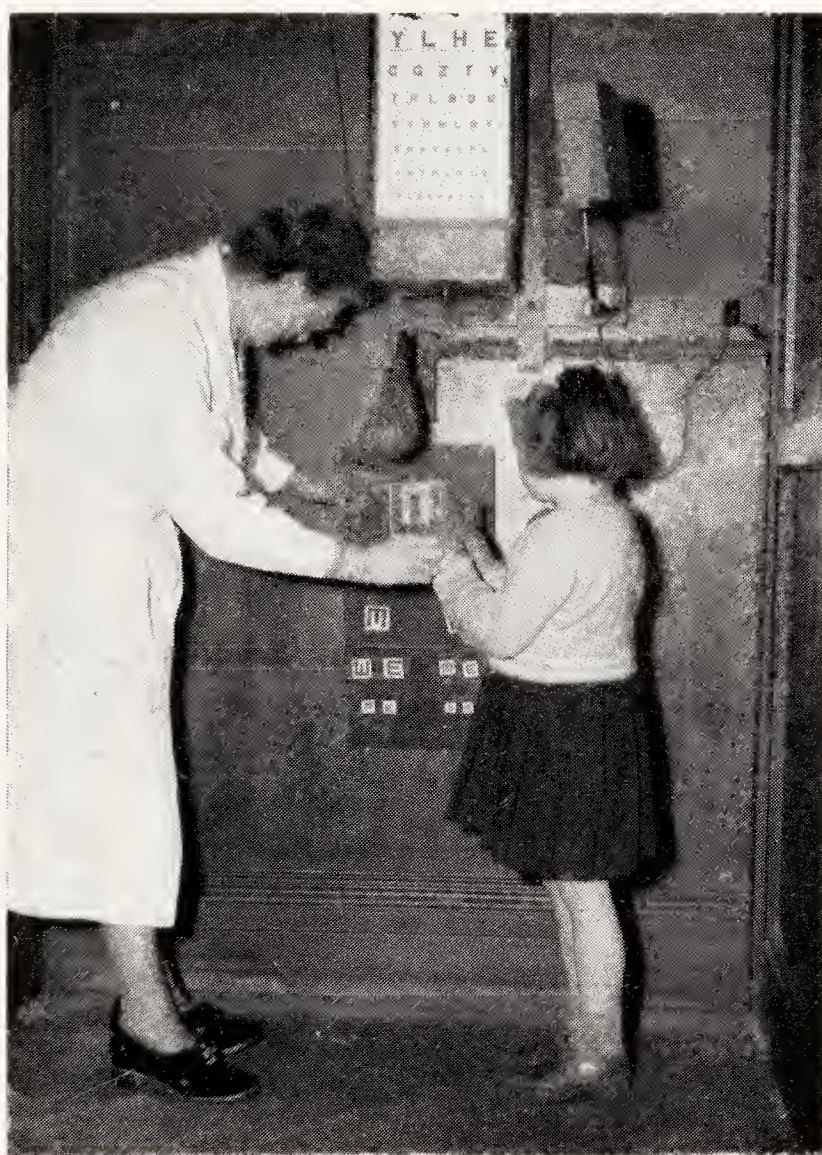
Dental Inspection in School.

Eye Clinic.

Cases are referred to the eye clinic from the following sources :—

Children sent by medical officers during medical inspection in the schools, children referred by school teachers, children recruited from the maternity and child welfare clinics, children brought by parents themselves and, lastly, children referred by opticians.

With the exception of those cases referred from the maternity and child welfare department, the children in schools are examined by the medical officer, health visitor, or school nurse, at the age of 7 to 8, either by means of Snellens Test Type, or if illiterate, with the aid of the Illiterate E Test.



The illiterate " E " test of vision for children unable to read.

The clinic is receiving increasing help from the teaching staffs in the schools in the matter of referring cases. The co-operation between the teaching staffs of the schools in Salford and the ophthalmic clinic has been the practice for many years. The following is a quotation from the report of the Chief Medical Officer of the Ministry of Health for 1946/47 :—

“ One cannot over-emphasise the importance of securing the teachers' help in the discovery of young children with defective vision. As they are in constant touch with children they are in a better position than anyone else to detect symptoms, such as holding a book too close, difficulty in seeing the blackboard, adopting a bad position at the desk, or showing signs of educational retardation—which may be indicative of defective vision.”

There has been an increase in the number of educationally backward children sent for examination, but in not more than approximately 30 per cent. is there any marked defect in visual acuity. Even, however, when the sight is found to approximate to normal, it is not felt that an interview with parent and child is wasted time. The parent, without exception, is pleased to discover that a visual defect is not present and this further emphasises the need on the part of the parent to share with the teacher the responsibility of giving special encouragement to the backward child.

There is a steady reference of cases from the Maternity and Child Welfare Department for squint or lacrimal obstruction. The latter condition is restricted to children in infancy or between the ages of one and two and responds to local treatment for a few weeks or months, in the majority of cases, and it is only a small percentage of cases which require lacrimal probing in hospital. The usefulness of the early reference of cases of squint cannot be over-emphasised in the pre-school child. In recent years there has been maintained a constant reference from the Maternity and Child Welfare clinics of children with this defect. They are refracted under mydriatic, and glasses, where necessary, are often prescribed within a week or two of the squint occurring.

Not a few children just out of infancy but able to walk are fitted with "tie-on" spectacles for constant wear. The mothers of the older pre-school children (ages 3 to 4) are particularly gratified with the early improvement in visual acuity in the squinting eye as a result of occlusion and the wearing of glasses.

Since the inception of the National Health Service Act there has been a noticeable increase in the number of parents who bring their children for eye examination when any defect is suspected. This is in marked contrast to the prejudice against the wearing of glasses not so many years ago.

Lastly, and importantly, the rapid surveys of children in schools, including eye-testing, brings to light children with visual defect who have been missed at routine inspection due to illness or for other reasons.

It will be appreciated that the young patients drawn from these several sources represent a high percentage of the school population in the City which suffer from visual defect.

REFRACTION CLINIC.

At this clinic 10 to 14 cases are sent for per session and the waiting list for patients to be seen is no longer than three weeks. If a child does not attend at the first invitation, the invitation is repeated for three times at intervals of a fortnight or three weeks. If no response occurs to the invitations, the child is home visited. As a result of these efforts, less than 5 per cent. of the children come into the category of defaulters. Occasionally, the child or the parents do not collect the glasses from the optician and a home visit is made as a result. Since the inception of the National Health Service Act, there has been only one child who has not secured its glasses.

CHILDREN SUFFERING FROM HYPERMETROPIA.

Children with hypermetropia are not prescribed glasses unless they have symptoms or persistent physical signs. This applies especially to the younger children under the age of nine. In practice it has not been found useful to correct the hypermetropia of moderate or medium degree in the younger child because—

- (1) he does very little close work and is generally symptom free ;
- (2) it has been found that when corrected the child does not wear the glasses ; and
- (3) the parent is not desirous that the child should wear glasses unless he becomes aware that a visual defect is present.

Such cases are seen every twelve months and if the hypermetropia persists in the latter school years and symptoms become noticeable a correction is then prescribed.

All cases of myopia are supplied with glasses and are re-examined every six or twelve months according to the youth of the child and the rapidity of advance of the short sight. It is found in such cases that the glasses are generally worn constantly because of this improvement in vision, which is appreciated by the child.

High School pupils with visual defects are examined during the school holidays so as to obviate interference with school attendance.

In the examination of children suffering from refractive errors the normal routine after a test of visual acuity is the prescription of 1 per cent. atropine sulph. in drops or ointment for a period of three days, followed by refraction. The patient is then invited to attend in two weeks for a post-mydriatic test, and glasses are then prescribed if necessary.

Artificial eyes are now supplied free of charge, and it is gratifying to note that none of the few children to whom this applies has been without an “ eye.”

All repairs and adjustments are dealt with immediately and are not placed on the waiting list. All cases sent as “ urgent ” by teachers and doctors are given an early appointment, as are child welfare cases and older children accompanied by parents who are concerned about their children’s sight.

SQUINT.

These patients usually have a hypermetropic refractor error. They are examined under a mydriatic and glasses are prescribed when necessary. All such cases are referred to the orthoptist and are seen by the latter within three months of the time of refraction.

Patients undergoing occlusion are seen monthly and when the vision is equal, or nearly so, at three-monthly intervals.



Orthoptist treating squint by occlusion.

Orthoptic training may be given at the earliest at the age of 7 years and the child attends the clinic at weekly intervals. A waiting list for those children requiring operation is compiled following orthoptic investigation, and the cases are classified according to the type of squint.

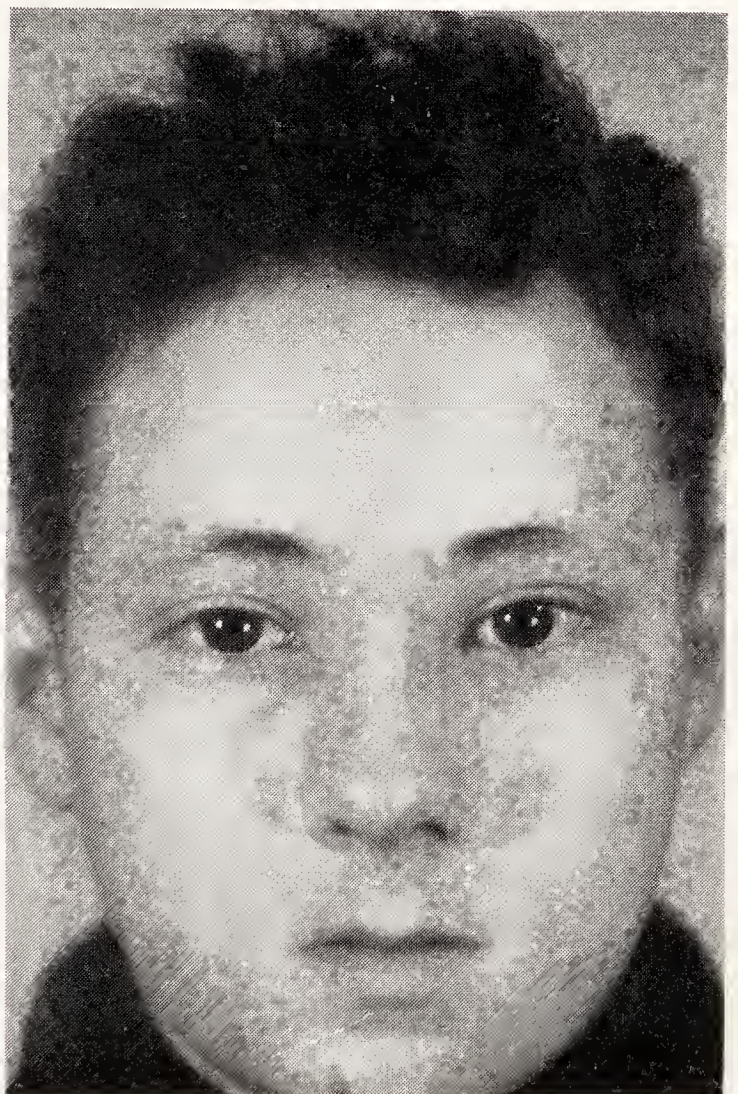
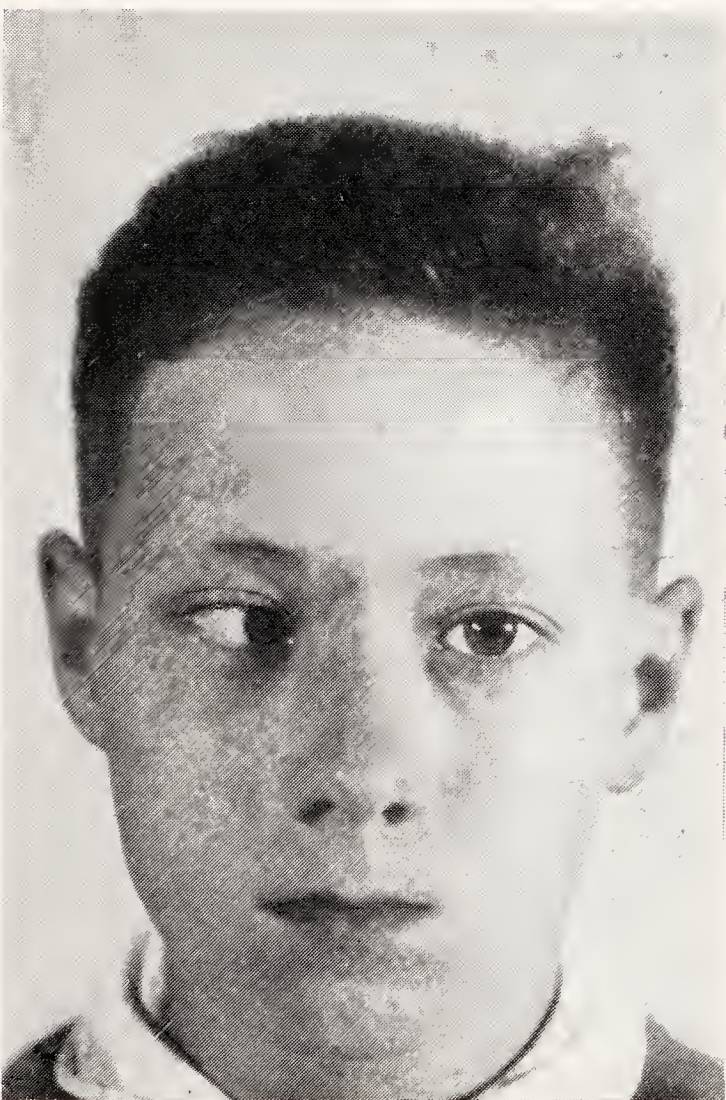


Treatment of squint by the use of the synoptophore.

During the past year the clinic has had the services of two part-time orthoptists, so that ten sessions per week are now fully staffed. It has been possible to supervise a greater number of children per week by means of occlusion and to increase the number of orthoptic treatments to 16—20 per week. A greater percentage of squint patients are now receiving orthoptic training either alone or combined with operation than previously. On an average 120 cases of occlusion are seen weekly and 20 cases receive orthoptic training weekly. This has resulted in a gradual increase in the number of orthoptic cases submitted for operation.

Operative sessions are held fortnightly at Hope Hospital when a list of 2—3 patients are operated on for squint.

	<i>Boys.</i>	<i>Girls.</i>
Attendances at Orthoptic Clinic for occlusion and routine inspection	2,339	2,034
Attendances at Orthoptic Clinic for treatment	393	347
New cases of Strabismus	155	197
Number of refractions	2,405	
Number of cases of eye diseases	255	
Number of pairs of glasses prescribed	1,418	
Number of pairs of glasses obtained	1,418	
Operations for 1951	18	20



An example of the beneficial effect of operative treatment for squint.
The illustration shows a child before and after treatment.



An example of the beneficial effect of operative treatment for squint.
The illustration shows a child before and after treatment.

PARTIALLY-SIGHTED CHILDREN.

In September, a class accommodating 15 children was established at the new Claremont Open-air School. The option of attending such a class is given to those children whose visual acuity is 6/24 or less in both eyes, from whatever cause. Such cases consist of rapidly advancing myopia in children under the age of 10, and children suffering from congenital defect which is unimprovable and is associated with refractive error. It is the policy, as far as possible, to restrict the age range to between 6 and 11 years so that for educational purposes a class of up to 16 children may remain within the teaching scope of one mistress. The children are taken to the school by 'bus and have a mid-day meal and tea on the premises. The school is situated in hygienic surroundings. Care is taken not to give the child the impression that he is an "ocular invalid," and the teaching, which is individual for the greater part, conforms to the usual methods except in children whose visual acuity is 6/36 or 6/60 where the use of a visual aid apparatus is made available.

When it is found that the myopes are stationary, i.e., that the condition is not worsening, the child is encouraged to return to the ordinary school for the last three or four years of his school life. The same policy is adopted for the congenitally defective children and when the visual acuity is not below 6/36 it is arranged for such children to sit on the front row in the classroom on return to the ordinary school.

COLOUR VISION TESTING.

A survey of the older children from 11 onwards is in process of being made in the grammar and senior modern schools for both boys and girls. The method used is first the group test using the Colins-Drever group test, followed by the Ishihara colour vision test where cases of suspected defect

are noted. This survey has been interrupted due to the darker months of November to February, when the daylight necessary for such a test cannot always be relied upon. The figures of this investigation will be reported later when it has been completed.

INTERNAL EYE DISEASES.

These are discerned on internal examination of the eyes under mydriatic drops, and are comparatively rare. Treatment is advised, and the child is seen frequently. As these are often due to general causes, the child is referred to special departments such as the municipal clinic, tuberculosis department or to hospital for further treatment which cannot be given at the clinic.

EXTERNAL EYE DISEASES.

These comprise external diseases of the eyes and lids and are often referred from other clinics. The number of cases varies with the time of the year, such diseases being more prevalent in the spring and autumn when there are cold winds and invariable weather. General health is usually lower in spring following the winter. The children are examined and they are referred for treatment to the nearest school clinic and continue treatment at home.

Cases of blepharitis are becoming rarer, due to modern methods of treatment which are applied regularly, and because of persistence in treatment after an apparent cure. It is also due in many cases to the wearing of spectacles for correcting stigmatism. The more serious types of inflammation such as phlyctenular conjunctivitis and ulcers of the cornea, both of which are likely to lead to defects of vision, are also not so frequent. This again is due to modern medicine clearing up the condition more quickly, before permanent injury is done to the eye, and also to the children's persistence in the treatment both during and after the attack. In many cases these are due to low general health and the children are referred to the sunlight clinic and given cod liver oil and malt or other vitamin supplements.

The acute suppurative conditions are rarely seen now because the child is treated in the early stages before the deeper tissues are involved.

“Styes” are not seen so frequently now, and the milder infections of lids and conjunctivæ are treated and cured before they involve deeper tissues and the condition becomes chronic.

The milder conditions of conjunctivitis are still seen, but quickly clear up under regular treatment, and leave no after-effects.

These children are rarely advised to be absent from school as experience teaches that the condition clears up more quickly when the child attends school and clinic regularly, which he tends not to do if absent from school. The risk of infection to other children is very remote, except in the rare cases of acute suppurative conditions. In many cases both parents are at work during the day leaving the children to play unsupervised in dirty surroundings, and aggravate their condition by rubbing the eyes. In school, however, under more regular supervision such aggravation is often avoided.

Speech Therapy.

Speech therapy is quite distinct from other forms of speech work such as elocution, which is not concerned with the original purpose of speech—communication—but which endeavours to improve the existing mode of language as regards diction, voice production, to beautify words and give them meaning and charm.

Speech therapy is the remedial treatment for all types of disordered speech. Remedial speech is wholly constructive and is applicable to individuals who, through failure of development, injury to brain, emotional disturbances or physical malformations, are prevented from normal oral contact with the world. The aim of speech therapists is to build up confidence and self-control in the speech defective child through speech rehabilitation, so that his outlook on life becomes positive (speech defect often causes maladjustment of whole personality inasmuch as the person concerned is liable to feel different).

Deafness may be a contributing cause of dyslalia (general term for defects of articulation). Speech is learned by hearing and imitating the spoken word, and if a child hears imperfectly, speech is likely to be imperfect too. Structural defects such as some dental irregularities protruding or retracted jaws, cleft palates, affecting speech mechanism also affect production of the speech sounds. Dyslalia often results from lack of training in speech and where there is language poverty in the home. If a child does not receive the right stimulation and training in speech—speech development will be affected. Sometimes a child's wants are anticipated by parents. He has no need for speech so he uses gesture.

In mentally retarded children general development is usually slow, inception of language late, speech development retarded (perhaps the abstract nature of words makes it difficult for the mentally retarded child to grasp meaning). There is usually little improvement in speech of this type of child. It is understandable if the therapist feels that such work should not take up her clinic time, but in the interest of public health, children should not be debarred altogether from treatment. In point of view of the welfare of a child as a whole, he frequently gains a feeling of security from coming to the clinic, and can be stimulated to move towards self-expression and communication.

In the treatment of dyslalic children we should remember we are dealing with a speech defective not with specific consonants. Basic causes are removed or improved where possible and the child's speech re-educated through ear training—child is taught to listen, imitate and learn—through tongue exercising and manipulation.

There are many kinds of *speech defects*—from complete speechlessness to disorders of *pitch*, and strength of voice.

Causes include hearing loss, strain, vocal abuse through singing and shouting, hypertension, emotional maladjustment, disturbed breathing, or it may be hysterical. *Treatment* depends on the underlying cause.

Stammering—one of the most common of speech defects—has to be overcome by building up confidence within the patient, releasing him from nervous tension. Any environmental or psychological upset is adjusted wherever possible. For any defect it is essential that there should be co-operation between school and parent.

It is the aim of the speech therapists that children with speech defects should visit the speech clinic nearest to his or her own school, at the same time having regard to a fair distribution of the work load. The opening of the new Langworthy Centre was a great advantage.

Throughout the year, certain of the children attending the special class for children suffering from cerebral palsy have continued to receive speech therapy treatment once a week. Two, who became in-patients at Hope Hospital, were visited there as frequently as possible by the speech therapist—though these visits were largely of a social nature—with the intention of reassuring the children that they hadn't been forgotten.

During the year several short talks on speech therapy have been given to student nurses from Pendlebury Children's Hospital, to a group of student Health Visitors, and to the Salford Young Teachers' Section. This dealt with the ways in which the teacher could help a child suffering from speech difficulty.

Here are some actual cases of children with speech defects :—

LATERAL SIGMATISM.

Norman, at 9 years, is a most co-operative child. He had a marked lateral sigmatism (Welsh 'll' sound for 's') when he first came for treatment. At 2 years, when he was just beginning to speak he fell, injuring his chin on a step and biting through his tongue, which had to be stitched. This tongue injury may account for the defective sound, which would be easier for him to say than the normal 's' sound. Lateral sigmatism seems often to be associated with aggressiveness. There may have been some rebellious attitude on the part of this child against his mother, who was suffering from a severe neurotic condition.

He is of good intelligence (he rates among the first four in class examinations), he was able, after a short period of intensive ear training using his own faulty sound in words and the normal one, to hear the difference, and was soon using the normal 's' sound. Quite often he had lost marks in reading because of his defect and he was determined that this defective sound should no longer stand in his way. After two months of treatment the 's' sound is now properly articulated in every position and combination, except occasionally in story telling and in conversation—but here he is able immediately to correct his faulty sound. He has now been given provisional discharge.

DYSLALIA.

Elizabeth, 8 years, lives in a very poor home and has had little opportunity to hear a good speech model in the home. From being a baby she seems to have been unwanted by her parents. Even now her parents leave her alone in the house while they go out and enjoy themselves. When first interviewed all her final sounds were omitted: 's' and 'f' were lisped (th); cat was 'tat'; yes was 'les'; rabbit became 'wabbit'. Her voice was rather husky, her tongue thick and sluggish, lip and tongue movements poorly co-ordinated. Because of the poverty of speech in the home, her parents were not asked to give Elizabeth daily practice in speech. The school, however, has been exceedingly co-operative. Elizabeth used to be naughty in school deliberately to attract attention she craved. Now, happily, with an older girl bringing her to the clinic and her teacher giving her daily speech practice at school (he will spend about 10 minutes each day giving her tongue exercises and speech practice from her speech notebook) she feels she is having the care and attention so lacking at home. Progress has been very slow and improvement in her speech condition only slight.

SEVERE HYPERNASALITY.

John, now 14 years, had his tonsils and adenoids removed when he was 8 years old. After operation speech was nasal in quality. Exercises, including blowing exercises, were adapted for him from those used in cases of cleft palate speech, but improvement was only slight. After a lapse of two years in treatment, speech had become severely hypernasal. The palate, on examination, was very short and not very mobile. There was nasal escape on all his speech sounds. Could he hear this nasal quality in his speech? When questioned he admitted that as far as he knew there was nothing wrong with his speech and confided he often wondered why he should attend for speech therapy treatment. His speech was recorded and played back to him and he heard his hypernasal speech for perhaps the first time. The mechanism of palate function and dysfunction were demonstrated to him, using detailed diagrams and explanations to arouse his interest. The soft palate was exercised and massaged to try to promote movement—but unsuccessfully. He was referred to the plastic surgery unit with a view to performing a plastic operation which would enable the soft palate to reach the posterior wall of the pharynx and thus obviate nasal escape.

IDIOGLOSSIA.

Robert, aged 6 years, was extremely timid when interviewed. His tiny voice was often little more than a whisper. Speech was characterised by vowel sounds, a ‘p,’ ‘b’ and ‘m’ and ‘k,’ which was used for every other consonant—father was ‘kakuh,” gate was ‘kay’—at school became ‘akoo.’ A younger brother through imitation showed a similar defective speech pattern. The case history revealed the interesting fact that the child was born choking—the cord wound tightly round his neck. Could this have some bearing on the particular “backed” form of the defective speech? Although an I.Q. was not taken, the child was noted to be mentally very alert from the way he so quickly began to learn his new sounds and use them in speech situations outside his weekly treatment lessons. In his first lessons words like ‘bob,’ ‘map,’ were practised (using the sounds he could say). He is now practising the ‘th’ sound in words and sentences.

Treatment throughout has been individual and therefore concentrated. His mother, so sensible and co-operative, has given her child daily practice in the carefully selected words and sentences given for home practice each week.

GENERAL DYSLALIA AND LATERAL SIGMATISM.

Margaret : aged 8 years 5 months. On admission to speech clinic, appeared very frightened and nervous child. Poor home : mother tired and overworked bringing up large family : home drab and cheerless. Margaret brought to the clinic by her elder sister. Clothes had a neglected look. Child spoke in a small timid voice. Very backward reader. Showed a high, narrow hard palate, and there was gross open bite of the front teeth. Mouth breather. Final consonants not sounded at all.

A month after treatment started child had sufficient confidence to attend speech clinic on her own. Mother reported that she liked coming. Showed more initiative.

Referred to orthodontic specialist who stated the open-bite was caused by tongue-thrusting, and of the opinion that this was psychological. Parent and child then referred to Psychologist.

During attendance at speech clinic deafness was suspected, and Margaret was referred for hearing test (very fearful at the idea of it and needed to be reassured). Found to be suffering from fairly severe high tone deafness. Teacher informed at her school and child placed in front row of the class. Child seen by ear, nose and throat specialist who ordered treatment for catarrh. Child and mother co-operated well. Child given breathing exercises at the speech clinic to help the nasal catarrh. Speech correction made good progress. The lateral sigmatism disappeared and ends of words were sounded. Given provisional discharge after 1 year 10 months' treatment. Check-up at school 3 months later showed that progress had been maintained. The child's speech was satisfactory and she appeared much more confident.

STAMMERER.

Ernest : aged 13 years 3 months. When admitted to speech clinic was stammering very badly. It was stated at interview that mother had left home three years previously. Ernest joined a class of three other boys at the clinic. At first inclined to bully and tease a younger member (not in front of therapist). He lacked confidence, and hung his head in a shamefaced way. Voice hardly above a whisper. Very backward reader, but showed marked aptitude for drawing. His earlier drawings were always of strong men (said he would like to be a P.T. Instructor), but later drawings showed more variation. He did well at competitive games, and the reassurance that he was not dull increased his confidence. (It was pointed out that he showed a tendency to mirror-reading, but that this could be overcome with practice). Ernest's bullying tendencies disappeared. His reading difficulty lessened. At the end of a year's treatment his whole manner and bearing had undergone a change for the better. Six months later his stammer had vanished completely, and he was given a final discharge as he was about to leave school. A school visit confirmed the fact that the stammering had ceased. A month or so later Ernest visited the speech clinic with a note from his headmaster. His speech and manner showed every confidence. Said he was now in the decorating business with his uncle. Both the school and home had encouraged Ernest in his drawing and painting : his father apparently having considerable artistic ability.

STAMMERER.

Raymond : aged 14 years 9 months : attending Technical School. First admitted to speech clinic for a stammer at 8 years of age—then treatment lapsed. Mother had died three years previously. On readmission the boy was stammering very badly and this was accompanied by spasm (in which the tongue was protruded) which frequently rendered him completely mute. Appeared very withdrawn. Looked glassy-eyed and stared fixedly at the therapist while attempting to speak. He was referred almost at once to the Child Guidance Clinic for special psychological investigation. Following an interview there, he was given priority admission, but continued to attend the speech clinic at his own wish after special treatment had commenced. (His father gave no co-operation during treatment). Nine months later, the nervous tension was greatly reduced and the eyes had assumed a normal expression. Stated that he was now able to answer questions at the lectures. After a further two months, progress was still maintained—the speech appeared almost fluent, also reading aloud : (told the therapist that he had read a whole page of Shakespeare aloud in class at school without stammering). Two months later he completed his treatment with the Child Guidance Clinic prior to leaving the Technical School where he had been studying engineering.

IDIOGLOSSIA.

George : aged 8 years. When admitted to speech clinic was substituting 'k' for most of the consonant sounds. Speech was unintelligible. Boy had a squint in the left eye (wearing glasses). Backward reader. Suffering a good deal from catarrh, sore throats and colds. Referred for medical examination. Seen by specialist and found to be suffering from an inflammatory condition of the middle ear which was accompanied by some degree of deafness. Under treatment, the inflammatory condition cleared up although some slight degree of deafness remained. After the boy had been attending the speech clinic for five months his speech defect began to show signs of clearing up. At the end of nearly two years' treatment the boy was speaking clearly and was given a provisional discharge. His attendance throughout had been regular and his co-operation good. A school visit four months later showed that clear speech was now well established. During the time that he had been unable to converse freely at school, the boy had shown marked ability for clay-modelling, but when the speech difficulty cleared up he lost most of his former skill (this was reported by his headmaster).

Special Investigation Clinic.

During the past twelve months the scope of the Special Investigation Clinic has increased and has embraced problems other than those of respiratory disorders. In spite of this extension it is still possible to devote considerable time to the study of the difficulties of individual children. No more, and frequently less, than twelve children are invited each week ; not more than four of these being new patients. Thus time is available for a comprehensive diagnostic consultation. The consent of the general practitioner is obtained before the child is invited and a report is sent after the consultation.

Facilities for certain simple investigations are available on the premises and more detailed examination is done at Hope Hospital by arrangement with the laboratory and X-ray departments. When long term investigation is necessary, children are transferred to the Paediatric Out-Patient Clinic at Hope Hospital, or, occasionally, are admitted to the wards. These steps are taken, for example, with cases of suspected bronchiectasis, primary tuberculosis, problems of growth and in difficult cases of enuresis.

In this way many of the facilities of the Hospital Service are brought to the child at the clinic and on many occasions mother and child are spared a visit to hospital. More time can be devoted to each case than is usual in a hospital clinic, the consultation being held in complete privacy and waiting time cut to the minimum. These advantages are particularly useful when dealing with emotional problems or disorders with a background of anxiety.

It will be noticed that the majority of children attending are suffering from respiratory disorders. Close co-operation with the Ear, Nose and Throat Clinic and the Chest Clinic makes the management of these children simpler than it otherwise would be. The impression remains that social and climatic conditions in Salford are directly responsible for much of this illness and apart from the solution of the housing and smoke problem it would seem that by providing a regular annual holiday in the country or by the sea for those children whose parents cannot afford such things, the physique of these children would be significantly improved.

One lucky child who had attended the clinic with asthma was taken by a Swiss family to live in the country in Northern Switzerland. She spent eight months in Switzerland and received only treatment such as she had from the clinic in Salford. During her stay she gained 20 lbs. in weight and had no asthma since she left England. She returned to Salford in December, 1951, and has had no further asthma. This does not necessarily mean that such improvement can only be found in the Swiss climate ! Close co-operation with the School Medical Officers ensures that the best use is made of the Open Air School facilities for handicapped and delicate children. The benefit is so obvious that it would seem wise to extend the facilities for treatment at the Open Air School so that children may be discharged from hospital earlier and might continue simple rehabilitation in more normal circumstances.

Report of the Work of the Special Class for Partially Deaf Children, Regent Road School.

The latest equipment acquired during the year by the special class for partially deaf children at Regent Road School, is a wire recording machine, which has been of invaluable use for the correction of speech faults, as well as causing great fun among the children.

Mr. Arthur Tordoff, instructor of the class, uses it to record the children's voices about every two months, and there is usually keen interest as well as utter amazement when they hear the sound of their own voices !

Since this class was opened in 1948 (for a maximum of ten children at a time) "hard-of-hearing" children have been brought to normal school standard, and children who were, for example, four years "behind" have been "coached" to normal in about 18 months to two years. Once the deafness has been realised then it is just a matter of patience, energy and hard work on the part of the teacher and pupil alike. There are so many supplementary causes of deafness, such as general health, which can include poor nutrition, poor clothing, susceptibility to colds and catarrh, home conditions, insecurity in the family, atmosphere in the home life of the child, mental outlook, frustration, introversion and many other hidden causes, which, combining with a genuine loss of hearing, affect children in a variety of ways. There is also "assumed" deafness, as in the case of a boy who had pretended to be deaf and acquired a "vacant" expression to cover up his constant pranks.

In a large class at an ordinary school slight deafness in a child could be passed off as definite educational subnormality, and thus he would sink lower and lower into the mire of despondency, until he becomes morose and apathetic. There is a warning here, too, for parents, who at the suggestion of a slight defect in their children look askance at the idea with the retort : "My child in a special class—never !"

The teaching of lip-reading is an essential part of this special class, and a touching story is told of the "superiority" of a deaf child over a normal one. At a performance of a school play two girls carried on a conversation across the hall, without a sound being uttered, much to the wonder and amazement of their fellow pupils !

Yet there are other not-so-happy cases. Take Betty, who had spent most of her early life in hospital, and as a result was several years behind her age both in knowledge and in intelligence. It seems pathetic that this smartly-dressed adolescent, whose chief pride is her nylon stockings, should delight

in jumping through a skipping rope with children half her age ! True, she has learnt to lip-read efficiently, but her constant absence through illness keeps her always below standard.

Then there was John—a “ case ” shrouded in mystery. His mother had deserted him, he had got into bad company, became a regular “ bad lad ” and finally came up before the city magistrates on charges of stealing. When he came into the special class he was on probation. But there is a happy ending to this story. John, who now feels he is cared for by somebody, is taking a keen interest in his lessons, and, as regards his probation, he has become a “ regular *good* lad.”

In addition to lessons the usual visits to museums and other places of interest have been arranged, and for their summer outing Mr. Tordoff took the children in his shooting brake to Birkdale.

Even though the children may never recover completely from their defect, they are no longer handicapped, and they have regained their happiness and self-confidence.

Hope Hospital School.

This has been a very busy year as, in addition to the usual number of “ short term ” cases, there have been many children in hospital for several months receiving orthopaedic treatment, and also a number of cases of tubercular meningitis. The latter have needed a great deal of very special attention owing to the fact that the majority of them have suffered from deafness.

With the improvement of drugs and treatment, cases of chorea and rheumatism are of much shorter duration now than formerly, and the incidence of rheumatism in particular has been comparatively rare.

Every effort is made to keep those children who are in hospital for long periods in touch with the outside world, and the new invalid carriage acquired in the spring has been a great boon.

There have also been a number of “ school visits ” during the year. Small parties of children have been taken to the Library Theatre to see “ Beauty and the Beast,” to the Festival Circus at the Opera House, to the provincial Festival of Britain Exhibition, and to Eccles Parish Church, for a lecture on architecture.

During Education Week, an exhibition of school work was held at the hospital, and an “ open ” afternoon at Cleveland House, in both of which the parents took great interest.

Spastic Class.

In December, 1950, the spastic class moved from Hope Hospital to quarters in Cleveland House, the new Child Welfare Centre, and this has been a very great improvement.

The classroom is large and airy and the children have benefited greatly by being able to move about more freely and easily. The garden, too, has been a great joy during the summer months, and the children were able to spend a good deal of time out of doors.

Owing to the more adequate accommodation the number in class has been increased, and the school dinner and mid-day rest have had very beneficial results on all the children.

Special furniture has been provided for the more seriously handicapped pupils, and this has helped greatly with posture and control. Most of the children are now in the infant age range, several of the older boys and girls having improved sufficiently to take their place in the normal school.

Here are some progress reports of children who have received special training in this class :—

1. (5 years of age). On entry “A” was very tearful and sobbed intermittently for a day or two then began to settle down and be friendly with the other children. He was unable to walk more than three steps unaided. His speech was poor and uncultured, and his handling of sense-training material clumsy. At meal-times he used a fork but not a knife. By the end of the year he had settled down happily and was able to walk alone though with lurching gait. He enjoys school activities, and his mother reports improved behaviour at home and absence of tantrums. He has attended the eye clinic and now wears spectacles. He handles sense training apparatus more accurately and nimbly, and can write own name. He knows letter sounds, can recognise and write numbers up to 7. At meal-times he is able to use knife and fork without difficulty and his diction and vocabulary have improved. He delights in being able to help more handicapped pupils.

2. (7 years of age). On returning to school after the Christmas holiday “B” was not well, but his health, height and weight have improved. Unfortunately his stammer has persisted. He has made considerable educational progress—from wordmatching exercises to reading at a 7-years level. Progress has also been made in writing and in number. He enjoys art and handwork, especially if the use of a needle is involved. His mobility has increased from being able to get around by holding on to furniture to being able to walk unaided, though with a staggering gait, round Cleveland House garden, without needing to pause for rest.

3. (12 years of age). In the early part of the year “C” began to show increased progress and during the year gained such self-confidence that it was possible, in view of his physical rehabilitation to consider his transfer to an ordinary school. In particular his reading became well established and despite set-backs due to indifferent health his writing became more accurate and more speedy. Whilst his number work is still considerably behind that normal for his age level, good progress was made. He is now completely independent in matters relating to washing, dressing, and feeding, and his gait is not unduly conspicuous, although one arm is useless and shows wasting. During the past year he has learnt to use scissors well, and is now able to make more sustained efforts in any handling process. This boy has now returned to his ordinary school.

Home Teaching.

There have been several changes in the Home Teaching Scheme during 1951. Two pupils reached their sixteenth birthday and were replaced by younger children. Miss Hall resigned in August and Mrs. Plunkett, a teacher from one of the special classes, took her place. As there was a waiting list of three pupils by September, it was decided to appoint a second part-time Home Teacher for them. Mrs. Seaman visited them during morning periods each week from September to December but unfortunately she had to leave Salford at the end of the term. Her departure coincided with the transfer

of two of her pupils into schools, one to the Biddulph Residential School and the other to the Spastic Group at Cleveland House. Her third pupil has now been absorbed into Mrs. Plunkett's group, and as there are no pupils on the waiting list, a second Home Teacher will not be appointed until the need arises.

The progress of the pupils in this scheme varies not only with their abilities, but with the amount of co-operation and help given by parents on days when the Home Teacher does not visit. Where pupils are capable of work on the three Rs, this forms the greater part of their studies, but there are some pupils who make little progress in academic work. The Home Teacher has to be ready to develop any interests which the weaker children show, and very easy occupations with handwork materials are all that some pupils can manage. The better pupils make rapid progress, particularly where parents take an interest in the work, and if their physical disabilities improve sufficiently they could be admitted into normal school groups.

The teacher continues to take a keen interest in this special work and in spite of difficult working conditions, and unorthodox methods of teaching which have to be adopted, the results show that, in most cases, their work is really worth while.

Claremont Open Air School.

This school, opened in September, provides accommodation for 150 delicate children and a small class of partially sighted children. Thus the long waiting lists for open air school education have been cut to a minimum, with obvious beneficial results.



The school is pleasantly situated in an elevated part of Salford and adjoins one of the city's parks.

All classrooms have sliding, folding windows on two sides and glazed folding doors at one end, which overlook the playground and provide access to an enclosed grass plot which is used for instruction purposes in good weather.

There are separate dressing rooms with shower cubicles for boys and girls, and a drying room is provided for the quick drying of wet outdoor garments.

A medical inspection—physiotherapy suite, including a waiting room for parents is incorporated in the building, and is used daily either by the assistant school medical officer, the physiotherapist, or the school health visitor.

Barr Hill Open Air School.

Salford children have been receiving special educational treatment at Barr Hill for almost thirty years.

Children with such handicaps as asthma, bronchitis, malnutrition, anæmia and crippling defects have, after a period of months, been fitted to return to their places in ordinary school.

Emphasis is placed on the value to health of fresh air, adequate rest and good food. Breakfast and tea are prepared on the premises ; dinner comes from a central canteen.

Lessons and playtime are spent in the open air wherever possible, and the children make good use of the playing fields at the back of the school.

The children are generally well-covered, but a war-time gift from America, consisting of long trousers, thick coats and siren suits, helps to keep out the cold in winter.

The majority of the children attending this school, and the Claremont Open Air School, are transported to and from their homes by school bus.

Care of the Diabetic Child.

There are six diabetic children in Salford—three boys and three girls—all of whom live happily at home. They or their parents are trained to administer insulin, to adhere to a special diet, and to carry out simple tests of urine, so that the disease may be carefully controlled. The children are under the regular supervision of hospital out-patient departments, and periodically attend the school clinic for observation. They lead an almost ordinary life, taking part in the usual school activities, such as games, dancing and swimming.

The 30-year-old discovery of insulin means that these children, who otherwise would have died, can, with care, live a full and useful adult life.

Occasionally and for various reasons, residential care may be necessary, but even here emphasis is placed on establishing the child's independence, so as to fit him to take his proper place in the world.

The Care of the Rheumatic Child.

Acute rheumatism in childhood can impair physical health, cause loss of education, years of physical incapacity and perhaps death relatively early in adult life. Close on 100 per cent. of deaths from heart disease before the age of 40 are a consequence of rheumatic carditis. It can clearly be seen then that our children must be protected against recurring attacks of this serious infection.

Better health education of parents, teachers and public health personnel will tend to ensure the early discovery of rheumatic children. Teachers, particularly, are in a good position to report signs of nervous instability and vague ill-health which often precede more definite evidence of rheumatic infection. Factors in the prevention of the onset of rheumatism have been listed as : smoke abatement, fresh air and sunshine, adequate nutrition, suitable clothing, sound footwear, skin cleanliness, adequate rest, regular exercise, and dental attention. It can be seen, from this, that concentrated and comprehensive measures of attack are necessary.

Notification of the disease is essential to any effort which attempts to deal with rheumatic fever. Since the 1950 Acute Rheumatism regulations came into force, 37 Salford cases have been notified. Twenty-one of these are children who were already known to be suffering from rheumatism and who were on the handicapped children's register. The remaining sixteen have been notified by general practitioners and hospital medical officers. All notified cases are referred to the pædiatrician for investigation and consequent observation.

Recovery from rheumatic fever is a story of gradual progress from bed through various stages until return to normal school life. If the child is only slightly incapacitated it may be sufficient merely to make minor adjustments in the normal school routine, such as special rest periods or transport to and from school. The child can be taught to avoid close contact with sufferers from colds or sore throats, and be instructed in the methods of prophylaxis against chills and getting wet. Provision can be made for additional milk and nourishment. For the home-bound child, educational instruction may be given by a home teacher.

Wherever possible it is desirable that the child leads a normal life with exercise and games. He should enjoy the activities of childhood in preparation for a useful adult life.

Educationally Sub-normal Children.

The establishment of three special classes for educationally subnormal pupils at Broomedge School has done much to bridge the gap caused by the inadequate provision of education suitable for this type of handicapped child.

Today, "the category of educationally subnormal extends over a wide range of mental ability, from the child who only needs some special help in ordinary school to the lower limit of those who can gain benefit from education in a special school. The emphasis has now shifted from certifying a child as 'mentally defective' (a term now confined to children who are ineducable at school) to discovering what is best for the child of subnormality, and trying to provide this for him."

During the year intelligence tests were given to 198 children, 46 of whom were considered suitable to continue their education in ordinary schools. Of the rest, 45 were recommended admission to a special class, 43 for admission to a day special school and 29 to be notified to the local authority as ineducable.

Part-time Employment of School Children.

Of 451 children examined and found fit to follow part-time employment out of school hours, 435 wanted to deliver newspapers and the others became paid errand boys.

Child Guidance Clinic.

1951 was a very disturbed year owing to changes in clinic staff. It began just after Dr. Hughes' sudden death in December, 1950. She had been Medical Director of the clinic practically since it was opened in 1941 and is very much missed in Salford. Many of her old patients and their parents have expressed this and their gratitude to her for what she did for them.

Dr. Dale, Mrs. Lewinsky and Mrs. Eysymont left to take up appointments elsewhere.

Up to Easter, Dr. Burbury and Dr. Wilde gave some psychiatric help but it was not until September that Dr. Model took up his appointment as Medical Director and the clinic was able to function fully.

Miss Bradshaw began her service as Educational Psychologist as Mrs. Eysymont's successor in January, 1952, so once more there is a full team.

In spite of these difficulties 137 children have been dealt with in the clinic, 52 of whom had a full examination by Psychiatrist, Psychologist and Psychiatric Social Worker. The total number of interviews in the clinic was 1,274, and there were over 230 home and school visits.

In the autumn two students from the Mental Health Course at Manchester University gained first hand experience in the clinic, and they will complete their training in Child Guidance there. Visits were also paid to the clinic by students in training in the Department of Education, Manchester University.

The clinic is called upon for help by various members of the community. It is a healthy sign that many parents ask for this help themselves.

In the clinic an assessment is made, as far as it is possible, of how far a child's difficulties are due to social, emotional or intellectual factors. The method of treatment is called "play therapy"; a child is usually unable to put his difficulties into words, whereas in his play he often shows problems of which he may not be aware himself or cannot express in words. To give an example, a child may play with different dolls, each of which represents a member of his family, or each doll may represent part of his own personality. In the same way an older child shows his personality in what he chooses to do during his treatment session. The information which the child thus gives us has to be supplemented by what the parents or teachers report about the child's behaviour at home and at school and by what we learn of the parents' reaction to this behaviour.

Report of the Organisers of Physical Education.

A review of the many activities taking place under the heading of Physical Education during the twelve months ended on 31st December, 1951, shows that the standards already achieved have been maintained and that in most branches a steady, though unspectacular, improvement has been brought about.

The outstanding educational event in Salford during the past year was undoubtedly Education Week, held in March, 1951. The majority of schools included some form of physical activity in their programmes of special events during that week, and the demonstrations given proved an excellent stimulus to the subject. In addition, four Open Afternoons were arranged at the City Baths in which several schools combined to show various aspects of swimming, and the Salford Schools' Sports Federation arranged a Rally demonstrating the work of the various sections of the Organisation.

Following the pattern of previous reports, the various activities which go to make up physical education are reviewed in the following order :—

- (a) Physical training (including clothing and equipment).
- (b) Organised games and out-of-school activities.
- (c) Dancing.
- (d) Swimming.
- (e) Work in Youth Clubs.

(a) PHYSICAL TRAINING.

The daily physical training period forms part of the curriculum in all schools with the exception of Infants' Departments where the greater need for physical movement necessitates that both a morning and an afternoon period are given to the subject daily.

The work continues to be hampered by lack of indoor accommodation and the position worsened during 1951. This is due to the post-war increase in the birth rate which is reflected in an increased school attendance so that some halls previously available for indoor physical training have now to be used for one or more classes in general subjects.

In many schools there has been a change from the more formal type of lesson to that in which the children are given the opportunity to practise individual skills, and to experiment in movement. This results in the children being more versatile in movement. They develop greater control and enjoy a very real sense of achievement. The full use of apparatus both large and small is giving more enjoyment to both teacher and taught.

During 1951, eleven further Infants' and Junior Departments have been provided with some form of large apparatus which in the main provides the opportunities for climbing, hanging and swinging which are so characteristic of the work which children in this age-group enjoy and profit from.

In Senior and All-Standard Schools, nine further departments have received some large portable apparatus, and one Senior Department a fixed and portable apparatus. It is emphasised that it is impossible to make very much more progress in providing apparatus of this type for many schools within these age groupings, since there is little available space in some schools for using and storing it. It is obvious that in these cases, progress can only be made by the provision of new buildings.

The supply of small physical training apparatus to all departments has been maintained and an allocation of plimsolls has also been sent to every department in the City.

The removal of top garments continues but varies considerably from school to school. In the departments where this is not good, opposition comes mainly from parents, not children.

(b) ORGANISED GAMES AND OUT-OF-SCHOOL ACTIVITIES.

This section of the work maintains a steady interest throughout the schools, reflected in the increasing number of schools taking part in the various competitions promoted by the Salford Schools' Sports Federation as out-of-school activities.

The skills peculiar to the various games which are taught in the weekly organised games period are reflected in the improved standard of play in the inter-schools competitions.

Full use is made of all facilities provided by both the Education Committee and the Parks Committee. The Weaste and Ordsall areas still lack an adequate number of pitches and progress on the Northumberland Street site in Broughton, which is scheduled for girls' games, is very slow and the playing field still unfinished.

The Salford Schools' Sports Federation, which caters for out-of-school activities, reports a year's work of steady progress. The activities represent much solid work and purposeful endeavour, in encouraging coaching and a better standard of performance, a good spirit of sportsmanship and a higher ideal of the purpose of games.

The activities of the Sports Federation include Football (Rugby and Association) and Cricket for boys, Netball and Rounders for girls, and Swimming and Athletics for both sexes.

The Organisers of Physical Education once again would like to express their very sincere appreciation and thanks to the many teachers who so willingly give of their leisure time in controlling and coaching the many activities of the Association.

The results in the following activities of the Federation should have some mention :—

ASSOCIATION FOOTBALL.

Fifty-four schools took part. The City Team reached the Fourth Round of the English Schools' Football Association Trophy Competition, and the Semi-Final of the Lancashire Schools' Shield Competition in which they were beaten by Manchester. The Salford Association also staged an Inter-County Match between Lancashire and Northumberland.

CRICKET.

Two Salford boys were included in two County Holiday Tours and one boy was selected for the North of England (Schools) Team.

NETBALL.

There was a very successful season, the standard of play showing a marked improvement. In the Lancashire Schools' Netball League the City Netball Team were undefeated in all games and were only beaten by Manchester in the Final, very narrowly. For the first time the Lancashire Schools' Finals and All-in Tournament were staged in Salford. Two out of the three women teachers who sat for the "A" Umpires' Certificates (Part I) were successful in passing.

ROUNDERS.

The Rounders' Section of the Salford Schools' Sports Federation came into being during 1951. Sixteen schools took part in non-competitive rallies, and league competitions, the finals of which showed a surprisingly high standard of play.

ATHLETICS.

Two afternoons and one evening were devoted to Inter-Schools Sports. This year an innovation in the competitions was made by the introduction of Putting the Shot and Throwing the Javelin in the Senior age-group events.

EDUCATION WEEK.

A rally was staged to show the public some of the work done by the Football (Rugby and Association) and Netball Sections. In spite of bad weather, the many spectators were much impressed by the high standard of play and the excellent sporting spirit displayed by the boys and girls.

(c) DANCING.

This continues to form part of the curriculum in Infants' Departments and schools where there are girls. It is also taken successfully in one or two All-Standard Mixed Schools for mixed classes.

(d) SWIMMING.

Some extension of the work in this field has been possible since the Baths Committee have been able to extend the facilities for school children.

During the summer months, provision was made for 166 classes of 30 children and 16 classes of 20 children under eight instructors (four men and four women). In the first four months of 1951, provision was made for 62 classes to attend under three instructors (one man and two women). For the last four months of 1951, there was an increase in the winter swimming facilities available, the Regent Road and Blackfriars Road Baths being open for the first time for winter bathing, so it was possible to arrange for 89 classes under six instructors (two full-time and four part-time).

The standard of performance in swimming continues to improve each year.

Of the certificates given by the Education Committee, the following awards were made :—

Third Class Certificate	934
One length breast stroke.	
Second Class Certificate	837
Two lengths breast stroke.	
First Class Certificates	576
Two lengths breast stroke. Two lengths back stroke.	
Advanced	28
Diving, crawl (front and back). Breast and back stroke.	
Total number of Certificates awarded	2,375

The Baths Committee awarded 934 free season tickets to the children who gained the Third Class Swimming Certificate.

Twelve Medals were awarded by the Humane Society for the Hundred of Salford, four being allocated to girls and eight to boys, and 150 children were examined for these awards.

Awards gained by the children in the Royal Life Saving Society again show a marked increase. During 1950, 477 awards were made, an increase of 177 on the previous year.

During 1951, 621 awards were made, being a further increase of 144 awards.

The awards gained were as follows :—

Elementary Certificate	263
Intermediate Certificate...	190
Bronze Medallion	129
Bar to Bronze Medallion	31
Unigrip Certificate	6
Scholar Instructors' Certificate	2

The Education Committee has provided an incentive to children to become proficient in Life Saving since they decided to present the official costume badges of the Royal Life Saving Society to all children qualifying for the Bronze Medallion of that Society.

One outstanding event during the year was the Festival Swimming Gala promoted by the Baths Committee, in which the Salford school children provided the major part of the programme. The high standard of swimming by the boys and girls received very favourable comments from those present.

(e) WORK IN YOUTH CLUBS.

In the majority of Youth Clubs affiliated to the Authority, physical activity forms an important item in the work of these Clubs. In all of the many physical activities undertaken development has taken place.

In Indoor Activities there has been a steady development of physical activities during the past twelve months in all phases of indoor physical activities. Sixteen clubs provide facilities of this kind.

In Outdoor Activities substantial progress has been made and there has been an increased interest particularly in Girls' Netball, Girls' Rounders, Athletics, Rugby Football, and Club Holidays, sixteen clubs taking part.

Two Netball courses for girls and a Basketball course for boys were successfully arranged and well attended.

In Rounders the Girls' and Mixed Teams representing Salford in the Lancashire Rounders League Youth Rally did very well since they both won the Finals of their respective sections, this being the first time they had competed.

The Netball League has also done well, it now being necessary to run two sections of the League instead of one. In addition, the team representing Salford during the Stockport Youth Week were the winners of this competition.

A very successful Youth Sports Meeting was held on the Crescent Athletic Site, an increasing number of Clubs taking part and 11 records were broken. Representatives of the Ministry of Education who were present expressed their appreciation and approval of the improved standards of performance at this meeting.

Physiotherapy Department.

Physiotherapy has a great contribution to make in child health both for the normal and handicapped child. The emphasis now is on activity and happy exercises, not on passive massage. The help of the parent is all-important so that she can be told the "how and why" of treatment, and all the ways she can help at home by seeing that the exercises are practised there.

We also try to fit in with the school arrangements so that many children receive treatment after school hours on Saturday mornings. We try to lessen the distances the children have to travel, and as far as possible bring the treatment to the child in his school, rather than make him go to a clinic. The orthopaedic specialist, Mr. D. D. Cranna, holds a weekly session at the Regent Road Clinic, which is also attended by a technician who adjusts surgical appliances, and gives advice on alteration of shoes.

A new and happy feature of the service has been the closer co-operation with the Children's Specialists, since the children suffering from bronchiectasis are given postural drainage and breathing exercises.

ASTHMA.

The majority of children with asthma now attend one or other of the two open-air schools. They improve considerably with the exercises and the open-air school care, but the majority of the mothers will not make the effort to attend the school occasionally and watch the children do the exercises so that they may be practised daily at home.

Special waxed containers have been provided for use with postural drainage, and these are burnt after use to remove the source of infection from the sputum.

Breathing exercises are used for children after *tonsil and adenoid* operations. We consider that the small muscles round the nose and mouth become atrophied due to the open mouth breathing, and in these classes special attention is paid to lip and nose exercises to restore muscle tone and to remove the open-mouthed vacant expression often seen prior to operation. All children are invited for exercises after operation and are again seen by the specialist after a course of exercises.

CLEVELAND HOUSE.

Progress, though slow, is being maintained amongst these children suffering from cerebral palsy. The value of a routine school life combined with physiotherapy helps the child not only physically but mentally and emotionally. The school has been open in the new surroundings just a year, and by co-operating with the teaching staff treatment time and exercise time are made to fit into a working pattern very much to the child's benefit. Unfortunately during the school holidays the majority of parents do not co-operate by bringing the child to the nearest clinic for treatment, and a very definite sliding back is noticed after these weeks, so that at the beginning of each term much

valuable time is lost in retaining lost ground. At the beginning of each term the orthopaedic surgeon gives each child a thorough examination at which the parents are invited to be present. The surgeon then decides whether any surgical treatment or splinting is required, and the parent is given a full account of the child's attainments and can ask advice on any points which may be causing worry.

CLAREMONT OPEN-AIR SCHOOL.

Since September when the school commenced a physiotherapist has visited the school twice weekly to give treatment. A special bed for postural drainage has been supplied and after draining, breathing exercises are given. As more physiotherapists are available, daily physiotherapy will be given. There are now six children with asthma having breathing exercises. Within the next few weeks it is hoped that sunlight treatment may also be given at the school so as to spare the child the additional fatigue and loss of school time spent in going to and from a sunlight clinic.

SUNLIGHT CLINICS.

There has been a drop in the number of sunlight treatments this year. This can partly be explained by the fact that some medical officers are using breathing exercises instead of sunlight in the treatment of chest conditions. Another contributory factor is that since a school medical officer has a regular physiotherapy clinic, non-attenders, and children who have completed the sunlight course, are seen much sooner, and a quicker turnover is obtained.

Convalescence.

During the past year 119 schoolchildren in need of convalescence have spent four or more weeks by the sea or in the country away from the smoke-polluted air of Salford, from the narrow streets and overcrowded conditions, in which a large part of the population live.

The staff of Invalid Children's Aid Association were most co-operative in selecting the most suitable homes for the cases referred to them. Most of the children were sent away for four weeks, but in a number of cases some had to be away as long as 10, 12 or even 16 weeks.

Taxal Edge Convalescence Home, which caters for boys between the ages of 9 and 14, and which received 22 of the Salford children, report that "all types of boys enjoy their stay at the Home, but owing to the hilly nature of the country around we cannot take heart cases or boys who cannot join in the fairly active life they lead" here. To our surprise we have found that the Home is very suitable for asthmatic cases and think that this is perhaps because of the way in which the matron herself treats the boys. She keeps a careful watch on their diet, and, of course, they are not encouraged to think very much about their ailments. In addition to the warden here, who takes a keen interest in the boys, there is a social worker who is responsible for their outings and all their activities. There is no education at the Home, and this is something which we may have to consider in the future, although it would perhaps mean turning the Home into one for long stay cases. At the moment we think that the short-term Home is most needed. The boys at Taxal Edge are encouraged to "lend a hand" with the washing-up, bed making, serving, or for the more rustic types, helping in the garden or taking a turn with the hens. This will undoubtedly have the psychological effect of "making the boys feel *useful*."

It will generally be agreed that money spent on convalescence for Salford children is "money well spent." Take the case of 13-year-old Mary who had a constant cough and whose eyes had lost their sparkle due to a succession of sleepless nights. Her colour was leaden, she had no energy, and when first went away to the Home she was kept in bed for a week. At the end of four weeks her appetite improved, the roses returned to her cheeks, and she put on weight. She was glad to get home—her one-up, one-down dwelling—instead of, for "be it so humble" it was still home, and the sight of her mother brought that final lustre to her eyes.

Mary's case is just typical of the many cases of Salford children in need of recuperative treatment in fresher surroundings, to whom the smell of new-mown hay or the sniff of the salt sea air is unknown.

Yet there are other not-so-simple cases, where children are sent away for mental rather than physical recuperation. Seven-year-old Jean was the illegitimate child of a Salford mother and an American coloured soldier. Perhaps from a sense of guilt, the mother had an over-protective attitude towards her little girl, who always seemed to be catching one infectious illness after another, and developed bronchitis a week after she had been admitted to a day nursery. She had enuresis, which occurred day and night.

It is hardly to be wondered at that a child brought into a world under a handicap should be a psychological "case" living a life of insecurity and in need of a change for both body and soul.

It was some time before Jean's mother would consent to her child's being taken away for convalescence. Now the youngster is finally "having the break" and her trouble is beginning to clear up.

Jewish Fresh Air Home and School.

"Child of the town and bustling street
What woes and ills await thy feet !
And thou art cabined and confined
At once from sun and dew and wind ;
Fly from the town, sweet child ; for health
Is happiness and strength and wealth."

Several delicate Salford children between the ages of 6 and 12, in need of open-air treatment, carefully-planned daily routine and skilled care, have been away during the year to the Jewish Fresh Air Home and School at Delamere. They have benefitted from the pleasant surroundings, suitable education and treatment, and have been restored to their homes in health.

Many structural alterations and additions have been carried out in recent years at "Delamere," making the Home even more pleasant for the children, but this, of course, is a great drain on the funds, 40 per cent. of which come from voluntary sources.

The success of the Home springs chiefly from the fact that it has been developed along the lines of a large and happy family.

Salford Poor Children's Holiday Camp, Prestatyn.

During the year four groups of handicapped children enjoyed a week's holiday at this camp in pleasant surroundings and close to the sea.

Thus 240 handicapped children, making up the annual party of over 1,000 Salford children were given a holiday which they would otherwise be unable to afford.

There were visits to the nearby town, beach play, supervised bathing expeditions, and all the activities which make holidays so pleasant.

Sanitary Conditions in Schools.

Just as the arrival of a visitor encourages the "tickling-up" which must be done in a house, so the arrival of the sanitary inspector encourages—to a certain amount—the real cleaning which must be done, in the school as well as in the home. This does not apply to all schools and homes, but to those which have a particularly difficult job in "keeping up to scratch."

"Constant vigilance" is the keynote of the sanitary inspector's work, and there is no substitute for his *personal, regular* visits. He performs an essential part of our health service, looking after the environment of the individual from the cradle to the grave (and sometimes beyond). He is especially interested in school buildings, in which children pass so much of their time.

During the year the work of improvement has been carried on. Most schools can now boast decent sanitary conveniences and washing facilities, although there are still two schools with trough closets.

Outbreaks of food poisoning are diminishing due to constant routine checks on kitchens, utensils, and storage facilities. The work of the Food Inspector in his regular inspection of meat and other foods ensures that satisfactory hygienic standards are maintained. In addition there is the annual spraying of premises with D.D.T.

Post-war and economic difficulties, as far as patched-up schools with out-dated accommodation are concerned, also have their affect on the work of the sanitary inspector.

Mothercraft in Schools.

When asked by her teacher what she wanted to be when she grew up an 8-year-old girl said she "wanted to be a mummy." Now at the age of 19, the girl still wants to be a "mummy" and has just completed a high-grade course in domestic science.

This is typical of many young schoolgirls with domestic inclinations who would benefit by a simple home- and mother-craft training, and in most of the Salford schools a basic domestic science programme is included in the curriculum. Thus the foundations of the most important career of all—marriage—are laid, and a way is prepared for better home keeping and better health.

One Salford school has its own self-contained flat—the latest method of practical housecraft teaching. The envy of any homeless couple, the flat is the only one to be set up in a Salford school. It is "manned" by the "14s"

and “15s,” who in groups of four as “housekeeper,” “cook,” “assistant cook” and “housemaid,” run and live in the flat itself. Morning coffee and afternoon teas are served, and each lunch-time a complete dinner is served to which two guests (staff or girls) are invited. There is at least one tricky business—the careful preparing of the menus and the balancing of a suitable diet.

This encourages young people to take a keen interest in the home and family, producing long-term, worth-while results. A sensible homecraft training makes for a happy and healthy family, will appeal to the average person, and not allow her to neglect her children.

School Meals Service.

With no easing of the building situation in relation to the provision of new school canteens the year 1951 has been one of consolidating the position reached after some years of rather rapid expansion.

It has been possible to effect minor schemes of improvement at a number of canteens and dining centres on school premises and to prepare a major scheme of improvement for the Bowker Street Central Kitchen as a first step on the road to the closure of the Albion Street Central Kitchen.

During the year one new dining centre was opened for the Nursery Class at Regent Road Infants' School and a breakfast and tea service commenced at Claremont School Canteen for the children attending Claremont Open-air School.

The average number of meals provided daily is as follows :—

Dinners	12,000
Breakfasts	330
Morning snacks (Nursery Schools)	190
Teas	370

The annual total of all meals served is approximately 2,750,000.

The Education Committee continue to utilise the services of a Food Inspector for regular examination of food supplies, particularly the supplies of meat.

The external appearance of school canteens has not been overlooked and during the year a start has been made with the provision of soil and broken stone so that the canteen grounds can be made into attractive school gardens, modest expenditure on this having been approved by the Ministry of Education.

As a result of the national review, the charge to parents for school dinners supplied to their children has been increased to 7d. except for Nursery and Day Special Schools where the maximum charge remains at 6d.

The School Meals Service has had, in common with most other services, to face the problem of rising costs in wages, foodstuffs, and maintenance of premises, and since the cost of the service, subject to certain limitations, is met in full by the Ministry of Education only up to an approved maximum there is at all times a keen examination of expenditure both in London and locally. One result of this has been a reduction in hours of work of kitchen staffs.

Most certainly a great deal has been achieved for the benefit of the school child by the provision of school meals. In a service of such magnitude there remain many problems to test the energy and ability of all who desire to see the service become a real part of the education service as a whole. Teachers continue to take a close interest in the service, and without this it could not be so effective or so closely integrated into the school life of the child.

The Neglected Child of School Age.

Although sheer laziness on the part of parents may occasionally be the cause of child neglect, there are other contributing factors, such as ill-health or low mentality of parents, financial difficulties or psychological problems. In conjunction with other "helping" bodies, such as the Family Service Unit, the Civic Welfare Department and the National Assistance Board, the Health Visitor does all possible for the family—in the home and in the school. The aims of the Health Visitor are to co-operate with the teaching staff in helping unhappy and neglected children, and especially to influence older, and particularly, adolescent children not to succumb to the disorder and degradation of their homes. This is always an up-hill task, and it must be borne in mind that many parents' standards cannot be improved within any foreseeable time. To give some support to these children outside the home seems to be essential if they are not to follow in their parents' footsteps.

Three methods have been tried so far :—

- (1) Personal influence during the course of routine health and cleanliness inspections. Chronic infestation with head lice is a sign of persistent neglect. Some of the children are generally dirty and ragged. To teach them to take an interest in their personal appearance is a way of building up their self-respect, often sadly lacking.
- (2) Group teaching in the subjects of health, hygiene, mothercraft and home-making.
- (3) Social contact on special occasions, *e.g.*, school concerts, Education Week, etc.

Take the case of family "A"—a mother and nine children—who live in a terraced house in a Salford slum, which contains one living room and two bedrooms. Because of the low intelligence and ill-health of the mother, the frequent ill-health of the father when he was alive and the undisciplined household management, this house became a dirty den of neglected, unkempt children. Owing to the financial difficulty, the children received free meals at school and free clothing from the education authorities. Since the death of the father the house was a little cleaner, all the work being done by the 15-year-old daughter. One of the boys was under the supervision of the probation officer, whilst his elder brother tried in his own way to take the place of the father, but unfortunately using the wrong methods. While a "watch" was kept on the family things improved slightly. A second-hand settee had been bought, some decorating was done, and school attendances had improved. The adolescents in the family were being encouraged to join a youth club.

There is some improvement showing in family "B," where the mother a fat, dirty, garrulous, though pleasant-faced woman, now gets up in the morning with her five children and attempts to habit-train them, whereas previously she allowed the youngest ones to urinate on the floor. Since she was married she had never owned a house or furniture, but had drifted from apartment house to apartment house (never living in more than one room)

and had once been evicted. She had been shiftless, anti-social and uncivilised, had no regular schedule for cleaning or meal-times, and at a mid-day meal the father could be seen cutting chunks of bread from a loaf on a small wooden box, while the children helped themselves to a pot of jam. This family had very little crockery, and *no* cooking utensils. The father later went to prison for refusing to pay maintenance for his family, but after his discharge he disappeared and the police are still looking for him. The children have never had any toys or possessions of their own, which has encouraged them to steal from their mother. They are not physically ill-treated, and are happy-looking children. The answer here seems to be to educate the mother in household management as far as possible.

Family “C”—mother, father and four children (two of whom are in a reform school)—live in a new Council house, where there is no overcrowding. The parents drink heavily, are always in debt, and use bad language constantly. The house is usually dirty and untidy, but when “inspectors” are expected a general “tidy-up” is carried out, and on one occasion new curtains were made—but from stolen material, as it was later discovered. The mother has recently wanted to put the two younger children into a Day Nursery, but this was not supported by the Health Visitor, who thought that the mother ought to be encouraged to stay at home and learn to care for the children herself, and she felt that any extra money earned would be spent on drink and entertainment.

Whilst we are no doubt disgusted at the conditions under which some children are brought—or rather “dragged”—up, we can also see how easy it must be to produce a slum, when there is sickness and poverty in the home, bound up with many psychological factors. We have only to look at the house of an average family when mother is indisposed for a few days to see what a “pigsty” can be made of the place.

Health Visitors have to handle their “client” as they would a fragile plant, taking care not to bruise or break it. They must handle the family problem with the master touch, not creating more trouble, but acting on the good medical principle “if we cannot do any good, don’t let us do any harm.” They soon learn to differentiate between the people who would make a slum of any dwelling, and those, who with sympathetic help will eventually “make good.”

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STATISTICAL TABLES.

TABLE I.

Medical Inspection of Pupils Attending Maintained Primary and Secondary Schools, (Including Special Schools).

A.—PERIODIC MEDICAL INSPECTIONS.

Number of Inspections in the prescribed Groups—

Entrants.. .. .	3,020
Second Age Group	2,423
Third Age Group	2,054
TOTAL	7,497

Number of other Periodic Inspections 1,063

GRAND TOTAL 8,560

B.—OTHER INSPECTIONS.

Number of Special Inspections	6,731
Number of Re-Inspections	11,814
TOTAL	18,545

C.—PUPILS FOUND TO REQUIRE TREATMENT.

NUMBER OF INDIVIDUAL PUPILS FOUND AT PERIODIC MEDICAL INSPECTION
TO REQUIRE TREATMENT

(excluding Dental Diseases and Infestation with Vermin).

Group. (1)	For defective vision (excluding squint). (2)	For any of the other conditions recorded in Table IIA. (3)	Total individual pupils. (4)
Entrants	13	439	671
Second Age Group	358	302	703
Third Age Group	269	224	498
TOTAL (prescribed groups)	640	965	1,872
Other Periodic Inspections	3	198	194
GRAND TOTAL	643	1,163	2,066

TABLE II.

A.—RETURN OF DEFECTS FOUND BY MEDICAL INSPECTION IN THE
YEAR ENDED 31ST DECEMBER, 1951.

Defect Code No.	Defect or Disease. (1)	Periodic Inspections.		Special Inspections.	
		Number of Defects.		Number of Defects.	
		Requiring treatment. (2)	Requiring to be kept under observation but not requiring treatment. (3)	Requiring treatment. (4)	Requiring to be kept under observation but not requiring treatment. (5)
4.	Skin	130	295	618	225
5.	Eyes—				
	(a) Vision	643	51	74	36
	(b) Squint	84	151	27	22
	(c) Other	64	73	209	106
6.	Ears—				
	(a) Hearing	45	135	137	98
	(b) Otitis Media	64	166	531	209
	(c) Other	111	165	579	357
7.	Nose or Throat	204	1,586	1,387	1,584
8.	Speech	27	126	49	68
9.	Cervical Glands	21	743	235	519
10.	Heart and Circulation	19	266	266	713
11.	Lungs	63	392	543	877
12.	Development—				
	(a) Hernia	5	33	10	22
	(b) Other	6	86	10	21
13.	Orthopaedic—				
	(a) Posture	52	104	40	72
	(b) Flat Foot	40	71	17	21
	(c) Other	142	334	156	139
14.	Nervous System—				
	(a) Epilepsy	2	15	5	22
	(b) Other	13	132	125	257
15.	Psychological—				
	(a) Development	23	44	10	9
	(b) Stability	6	48	67	73
16.	Other	73	131	1,074	1,806

B.—CLASSIFICATION OF THE GENERAL CONDITION OF PUPILS INSPECTED DURING THE YEAR IN AGE GROUPS.

Age Groups.	No. of Pupils Inspected.	A. (Good).		B. (Fair).		C. (Poor).	
		No.	% of Col. 2.	No.	% of Col. 2.	No.	% of Col. 2.
(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)
Entrants	3,020	991	32·8	1,844	64·1	185	6·1
Second Age Group	2,423	855	35·3	1,453	60·0	115	4·7
Third Age Group	2,054	1,043	50·8	968	47·1	43	2·1
Other Periodic Inspections	1,063	358	33·7	642	60·4	63	5·9
TOTAL	8,560	3,247	37·9	4,907	57·3	406	4·8

TABLE III.

INFESTATION WITH VERMIN.

- (i) Total number of examinations in the schools by the school nurses or other authorised persons 74,857
- (ii) Total number of individual pupils examined 26,770
- (iii) Total number of individual pupils found to be infested.. .. 4,347

TABLE IV.

TREATMENT OF PUPILS ATTENDING MAINTAINED PRIMARY AND SECONDARY SCHOOLS.

GROUP 1.—DISEASES OF THE SKIN.

	Number of cases treated or under treatment during the year.	
	By the Authority.	Otherwise.
Ringworm—		
(a) Scalp	28	..
(b) Body	20	..
Scabies	56	..
Impetigo	107	..
Other skin diseases	949	..
TOTAL	1,160	

GROUP 2.—EYE DISEASES, DEFECTIVE VISION AND SQUINT.

	Number of cases dealt with.	
	By the Authority.	Otherwise.
External and other, excluding errors of refraction and squint	250	..
Errors of refraction (including squint)	*2,132	..
TOTAL	2,382	
Number of pupils for whom spectacles were—		
(a) Prescribed	*1,418	..
(b) Obtained	*1,418	..
TOTAL	1,418	

GROUP 3.—DISEASES AND DEFECTS OF EAR, NOSE AND THROAT.

	Number of cases treated.	
	By the Authority.	Otherwise.
Received operative treatment for—		
(a) Diseases of the ear	4	..
(b) Adenoids and chronic tonsillitis	620	..
(c) Other nose and throat conditions	2	..
Received other forms of treatment	44	..
Individual pupils seen at Pretonsillectomy clinic	244	..
TOTAL	914	..

* Including cases dealt with under arrangements with the Supplementary Ophthalmic Service.

GROUP 4.—ORTHOPAEDIC AND POSTURAL DEFECTS.

(a) Number treated as in-patients in hospitals	38
(b) Number treated otherwise, e.g., in clinics or out-patient departments	4,951

GROUP 5.—CHILD GUIDANCE TREATMENT.

	Number of cases treated.	
	In the Authority's Child Guidance Clinics.	Elsewhere.
Number of pupils treated at Child Guidance Clinics ..	137	..

GROUP 6.—SPEECH THERAPY.

	Number of cases treated.	
	By the Authority.	Otherwise.
Number of pupils treated by Speech Therapists	153	..

GROUP 7.—OTHER TREATMENTS GIVEN.

	Number of cases treated.	
	By the Authority.	Otherwise.
(a) Miscellaneous minor ailments	14,090	..
(b) Other—		
(i) Chiropody	556	..
(ii) Neurologist	54	..
(iii) Paediatrician	195	..
(iv) Sun Ray Clinic	1,548	..
TOTAL	16,443	

Child Guidance Clinic.

Number of cases referred, 1951, by—

Schools	24
School Medical Officer	43
Children's Officer	5
Hospitals	3
Private doctors	9
Court	6
Probation Officer	8
Parents	13
Others... ..	7
Outside Salford	11

129

Re-referred—Court	3
Hospital	1

4

133

Referred because of—

Enuresis and allied difficulties	15
Stealing and truancy	38
Failing at school	10
Stammer	5
Tics	6
Aggression	17
Sleep difficulties	6
Nervousness	11
Other behaviour difficulties	20
Advice, about placement... ..	5

133

Diagnostic interviews—

Full examination	52
Psychiatrist only	2
Psychologist and Psychiatric Social Worker... ..	43
Psychiatric Social Worker	3

100

I.Q.—

Over 130	4
120 to 130... ..	10
110 „ 120... ..	15
100 „ 110... ..	12
90 „ 100... ..	21
80 „ 90... ..	15
70 „ 80... ..	9
Under 70	5

91

Untested	9
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100

Waiting diagnostic interview, January, 1951 ...	66
Referred in 1951	133
	<hr/> 199
Seen in 1951	100
Closed without being seen... ..	44
Waiting to be seen, December, 1951	55
	<hr/> 199
Children seen for diagnosis	100
Children seen for treatment	61
Number of children seen	137
Number of interviews in the clinic... ..	1,274
Number of home visits	175
Number of school visits	60
Of those closed unseen (44)—	
Improved	16
Other agency	11
Unsuitable	2
Failed	9
Refused	5
Left area	1
	<hr/> 44

REPORT ON THE EXAMINATION OF CHILDREN SUSPECTED OF BEING EDUCATIONALLY SUBNORMAL.

Recommendation.	Boys.	Girls.	Total.
To be notified to the Local Authority as ineducable	15	4	19
Requiring supervision after leaving school... ..	3	2	5
To be admitted to a Special Class for educationally subnormal children... ..	24	21	45
To be admitted to a Day Special School for educationally subnormal children	28	15	43
To be admitted to a Residential School for educationally sub-normal children	10	1	11
To be referred to the Child Guidance Clinic (Maladjusted) ...	2	1	3
To be admitted to a Residential School for maladjusted pupils...	2	—	2
To be taken in care of the Local Authority	—	1	1
To be treated by Speech Therapist	3	—	3
To be admitted to a Special School for speech defects	1	—	1
To be admitted to the Spastic Class	1	—	1
To be admitted to a Nursery Class	1	—	1
For home teaching (physically handicapped and educationally subnormal)	1	—	1
To continue at an ordinary school	29	17	46
To be re-examined	12	4	16
	<hr/> 132	<hr/> 66	<hr/> 198

COMMENTS ON 1951 STATISTICS COMPARED WITH THOSE OF 1950.

Routine Medical Inspections. There has been a definite increase in the total number of children examined during the year both at routine and other inspections.

Ear, Nose and Throat Conditions. The number of defects requiring treatment and observation has increased. This is probably due to our improved specialist services in this field.

Lung Conditions. There is a marked increase in cases requiring to be kept under observation. This is due, no doubt, to the closer co-operation of the pædiatrician, and also to the improved accommodation for open-air school cases.

Hernia. The number of undetected cases of hernia is maintained. This is in spite of the fact that there are now improved facilities for these conditions to be diagnosed under the National Health Service. This is a pointer to the remaining need for the School Health Service, and the importance of the system of routine medical inspection.

Educational Subnormality. It is good to note an increase of 30 per cent. in the number of children examined, compared with last year's figure.

Minor Ailments. There has been a reduction of 2,500 attendances at the clinics during the year. I feel this is due in part to improved prophylaxis and to the National Health Service.

Records. It is pleasing to note that there appears to have been an increase in the number of defects recorded, as a result of the use of the new Form 10M.

A HISTORY OF THE SALFORD SCHOOL HEALTH SERVICE.

Over a hundred years ago the healthy children were usually those of the rich, aristocratic families, as we can see from the paintings of children at that time. Today, by first-class health services, such healthy children may be found, if not round every street corner, certainly in every school.

Aristotle, considering education, placed gymnastics, or physical exercises, as next in importance to reading and writing. The beneficial effect of healthy exercise was fully realised in Ancient Greece in 600 B.C.

Unfortunately, constant vigilance over the health of the child has not always been the accepted responsibility of the authorities and in the not-too-distant past the heart-rending sight of neglected, under-nourished children was as common, and as easily accepted, as the robust, healthy, well-cared-for school child of today.

Of the conditions of children in 1894, in Bradford, Margaret McMillan writes :—

“ Children in every stage of illness, children with adenoids, children with curvature, children in every stage of neglect, and dirt and suffering. The condition of the poorer children was worse than anything described or painted ; the half-timers slept exhausted at their desks and from courts and alleys children attended school in all states of physical misery.”

In the City of Salford with its closely-crowded buildings and factories and its inability to expand, the problem of overcrowding, as in all similar towns, is an ever-present one.

In 1835 the borough of Salford (Salford, Broughton and Pendleton) had about 55,000 inhabitants, but of these only 5,000 children were receiving any sort of real education. There were over 6,000 children whose only education was received in the Sunday School where, of course, writing and arithmetic were not taught on "The Lord's Day."

Teachers were so poorly paid that many depended on the poor-rate relief or followed additional occupations such as shop-keeping and washing. William Axon, a member of the Salford School Board in 1883, recorded that three schools had no books at all and only five of a total of sixty-five were tolerably well provided. Two schools were even kept in cellars and some in situations exposed to noxious effluvia. Most were overcrowded, dirty and damp. Many of the children in two schools were asleep when inspectors called. One master, whose wife and daughter begged him to remain at school, turned them into the street, locked the doors and marched off to the beer-shop where he spent the next fortnight ! Thirty scholars in a school with neither forms nor desks, sat on an old bed and an assortment of boxes, using an old three-legged table as a desk with barely room for three to write at once.

The wife of a Pendleton handloom weaver, lamenting her inability to send the children to day school, said, "they goon to Sunday Schoo', and larn a deal o' good theer."

The standard of teaching was so low that one crofter, after three years at a day school, could once read the Bible but had "quite forgotten how it's done now," and a woman said she didn't learn much because "the mistress used to set the scholars agate o' peeling potatoes and fetching water 'stead of setting them to read."

Many people, decent and hard-working, could not even afford to clothe the children, and kept them at home from shame, and what little had been learnt was soon forgotten. Most children were driven to work at an early age and one, unable to read, said, "I gaed to work when I should ha gaen to schoo'."

All in all the general opinion was that the education obtainable was so poor as to be not worth while.

Among the schools of that day we find the Manchester School for Deaf and Dumb, Old Trafford, the Poorhouse school, the Regimental School at the Infantry Barracks—92 children of soldiers taught by a sergeant—the Manchester and Salford National School, Salford, supported by subscriptions and donations and aided by an annual sum of £20 from the fund given in 1711 by a Mrs. Richards towards education and charitable uses. The Pendleton Day School was established in 1778 by neighbouring farmers. Charlestown Charity School, established 1834 by Mr. Hewitt, was supported by annual subscriptions and open to all denominations—the master had the use of the schoolroom rent-free with a salary of £10 per annum in addition to 1d. per week from scholars instructed in reading, 2d. for writing and 3d. for writing and arithmetic. Altogether about 18 schools are named.

In 1835 there were 5,700 children (10·3 % of the population) on the registers of the miserable schools of that day, and in 1882, when the population had trebled, the number of registered pupils rose to 29,800. The rate of increased attendance in the 10 years prior to 1882 was without parallel in the United Kingdom and was an important consideration in the educational problems of Salford.

With the machinery of the "School Board" and compulsory attendance there was less absenteeism. A marked educational improvement took place. In Salford the figure of passes in reading, writing and arithmetic was 92·8 % compared with 82·0 % elsewhere in England and Wales.

Absenteeism still created a serious problem, however, and every week some fifty parents came before the Bye-laws Committee to explain the non-attendance at school of their children. In the majority of cases absenteeism was due to carelessness but sometimes it was due to bleak and bitter poverty. Prosecution was resorted to only when all other measures failed.

Children reared in the depths of poverty and degradation, truants thieves, and associates of thieves, were dealt with by the Industrial School Committee. The Salford Board were at one time responsible for 300 children rescued from the prospects of a life of crime. The minor offenders were allowed home each night, because, whilst the Board were concerned for the welfare of these unfortunate children, it was felt that the parents should not be relieved of the whole of their responsibility. The more serious cases were sent to residential schools.

The information contained in the preceding eleven paragraphs can be found in William Axon's report to the Manchester Statistical Society on "Early Education in Salford."

Much has been done. Much remains to be done. The miserable damp cellar schoolrooms, and washer-woman teachers, such as existed in 1835, are gone. Salford has been well to the fore in the advances made in education and in giving to the poor but clever child an equal chance with the richer class. No longer is education the privilege of a favoured few but the birthright of all children.

As educational facilities were extended it was plainly seen that the child must be made fit to receive such education, and after a number of voluntary experiments in medical inspection, the local authority was given power in 1907 to provide for the regular medical inspection of children in schools. Since the first seeds were planted the school health service has grown beyond recognition.

This service has proved itself a branch of preventive medicine by giving a new emphasis to the importance of the "beginnings" of disease in childhood, by providing physical care and training between infancy and adolescence and so laying the foundation for health in adult life.

To attain the required standard it is vitally essential, said Sir George Newman, that :—

1. Every child, sick or well, shall periodically come under direct medical and dental supervision and, if found defective, shall be "followed up."
2. Every school child found ill-nourished should be properly nourished and every child found verminous should be cleansed.

3. For every sick, diseased, or defective child skilled medical treatment shall be made available either by the local education authority or otherwise.

4. Every child shall be educated in a well-ventilated, sanitary classroom, or in some form of open-air school, and an essential part of its curriculum should be instruction and training in hygiene.

5. Every child shall have daily organised physical exercises of appropriate character.

6. No child of school age shall be employed for profit except under approved circumstances.

7. The school environment and the means of education shall be such as can in no way exert unfavourable or injurious influence upon the health, growth or development of the child, physically and mentally.

These are simple propositions, but together they constitute a minimum standard of the physical claim of the individual child, of the child of the poor equally with the child of the rich.

Appointment of School Medical Officers.

It was in 1898 that the Salford School Board appointed a part-time medical officer, Dr. Hewson May, to take over the responsibility for medical inspection of schools and school children. This part-time service continued until 1902 when Dr. C. H. Tattersall became Medical Officer to the Education Department, and Dr. J. J. Butterworth was in charge of the inspection of school children, handicapped children, sanitary conditions of premises, and examining new buildings as regards sanitation ventilation,, lighting, etc.

In 1909 a card index system was instituted to ensure that each child should have a permanent record of medical inspections conducted at intervals throughout school-life. By 1911 over 4,500 children, involving over 12,000 examinations, had been treated, but this was less than half the requirements and an additional Medical Officer was appointed.

At this time there was much absenteeism from school due to physical defects, etc. The general standard of cleanliness was low, skin diseases and pediculosis being common. Among 5-year-old children 1·4% had impetigo, 9% had eczema, and 4% had other "sores." There were many cases of body vermin, and although four parents were fined during this year for child neglect, it seemed of no avail. Among the 12-year-olds 2·2 per 1,000 had epilepsy. Stammering was frequent, among the 12-year-old boys particularly, but breathing exercises, elocution and swimming appeared to have had beneficial effects. In three years, by 1914, the work had increased to include over 16,000 examinations, with the medical staff consisting of the Medical Officer of Health (who was also Medical Officer to the Education Committee), two assistant Medical Officers, a school dentist and four nurses. With the commencement of the First World War, the School Medical staff was seriously depleted by the requirements of the Army Medical Service. A modified service was carried on.

By 1920 there were seven members of the medical staff in addition to the medical officer of health. During the past thirty years the medical staff have seen many changes and each new arrival has brought fresh ideas concerning the improvement of the health of the school child.

Nurses in Schools. As early as 1880—27 years before a trained nurse was appointed by the local authority to inspect school children—certain Pendleton ladies provided the finance and organisation to supply trained nurses and midwives among the “poor” districts, which they split up into four—Weaste, Whit Lane, Brindle Heath, and Irlams-o’th’-Height. The nurses were controlled and paid from the Grosvenor Street Nurses’ Home, Manchester, until the opening of the Nurses’ Home, Crescent, Salford, in 1897.

One of the ladies instrumental in the supplying of the first trained nurses and midwives in Salford was Mrs. Charles Heywood, of “Chaseley,” Pendleton.

A keen social worker, she was a manager of St. Anne’s School for Infants, Brindle Heath. When this school was found insufficient for the needs of the area, and four nursery schools were opened in front rooms of cottages, all apparatus was provided by Mrs. Heywood. She also arranged with two milk dealers in the district to supply milk—one to three pints—to necessitous people, usually large families, and to school children. At one period she kept a herd of cows in the grounds of her home, from which she supplied milk to the children.

These nurses aimed at a high standard of personal cleanliness in the schools, and any child with a dirty head was quickly isolated from the class, put on to separate forms, and the mother of the child was sent for. The head-teacher would instruct the mother how to clean the child’s head, and—if the head had been frequently dirty—would suggest that the hair be kept short.

Usually the heads were very quickly cleaned and, only when the head-teacher had satisfied herself by inspection, was the child allowed to return to the class. Meanwhile minor ailments were attended to by the District Nurse in her own home, before she went out on her district.

I am indebted to the late Miss M. E. Boulton, of Salford, for the foregoing information concerning early school nursing care.

In the autumn of 1881 housewifery classes for schoolgirls were commenced. Miss Romley-Wright, principal of the Manchester School of Domestic Economy, provided staff to teach laundry and cookery, particularly invalid cookery.

Dr. J. J. Butterworth, deputy medical officer of health, Salford in 1907, gives the following interesting account in his annual report :—

“A Nurse has been appointed to assist in the inspection of the children.

Her main duty has been the detection of lousiness, and assisting at the special examination of children and teachers. Already a distinct improvement in the cleanliness of the children is observable in the schools where she has been working.

I have considered it better to accompany the Nurse on all her first visits to the schools.

The Nurse examines carefully the hair, heads, bodies and clothes of the children. Instructions are given to those children who are dirty. Special lessons in hygiene are given after the visit of the Doctor and Nurse in which the proper way to comb and brush the hair, etc., is dealt with.

The names and addresses of very dirty children are given to the School Attendance Officer who calls and invites the parents to come—together with the child—to the Education Office. The parents are there shown how to clean properly the children. They continue in attendance at the Education Office until the child is fit to go to school.

There are twelve Health Visitors associated with the Health Department. These Health Visitors are constantly visiting homes of the poorest class. It seems possible to associate the Health Visitors with the work of the Nurse. It has been arranged for the nurse to give instructions to those women in the methods of cleaning children, etc.”

The first trained nurse for whole-time duty in Salford commenced her duties on December 1, 1907, and on August 17, 1908, a second trained nurse was appointed. The schools in the Borough were grouped into two districts and one district was appointed to each school nurse. Four years later a third school nurse was appointed and, as Dr. Fitzgerald was also appointed to the medical staff, we were able to carry out the full requirements of the Board of Education regarding routine medical inspections.

By 1913 the work of the department had grown sufficiently to necessitate extra nurses. Examinations alone, at which the nurses assisted the medical officers, totalled 17,704 and in addition, treatments and routine duties were carried out.

With the outbreak of World War I, certain medical staff, and two nurses, left to take up military duty and, with a depleted staff, changes in procedure were inevitable. The three remaining nurses had to take over the actual medical inspection of children in schools, referring defects requiring medical examination, or treatment, to central office, where they were seen by the Senior Medical Inspector in the afternoons. This continued until 1917 when the number of whole-time nurses was again, fortunately, returned to five.

By 1920 twelve nurses, supervised by a superintendent nurse, were engaged in the welfare of the school child. This branch of the work is still increasing, and the school nurse is welcomed as a friend by children, teachers and parents.

School Meals. As early as 1895 we see a reference “have distributed 20 tickets each day for the Mayoress’s soup kitchen at the Town Hall.” The Education (Provision of Meals) Act, 1906, provided for the supply of meals to school children. The sanction of the Board of Education was obtained to spend, during the year 1912—1913, such a sum (not exceeding the amount which would be produced by a rate of one farthing in the pound) as would meet the cost of provision of meals under this Act. During the Docks strike of September and October, 1913, 1,748 children had 19,828 meals. Whilst school meals are not directly a part of the health service the adequate feeding of the child is a valuable contribution to his well-being. We are gratified by the wonderful development and high standard of this service. The present annual total of all meals served—dinners, breakfasts, and teas—is approximately 2,750,000. No school child need be hungry today.

Plato describes how children ate their meals to the sound of music, and sang praises “to the Gods”—the equivalent of our saying grace and having flowers on the table. During the school meals of today an unobtrusive attempt is made not only to cultivate the social graces but to teach food values, health habits and mutual helpfulness. School meals, at their best, can be of high educational and social value to the child.

CARE OF THE TEETH.

The reports for 1909-10 on dental inspection revealed some disturbing facts. Among 12-year-olds, 28 % boys and 25 % girls had over four decayed teeth, and among 5-year-olds, 44 % boys and 39 % girls had over four decayed. The proportion of decayed teeth would no doubt have been found to be greater had the examination of the mouth been made with dental probe and mirror in each case but the figures are sufficient to show the serious extent of dental caries among school children. They also show that the greater number of defects were found among boys and girls. "Urgent treatment was essential not only because of the pain but for other far-reaching effects such as inefficient mastication resulting in dyspepsia and poor nutrition, with enlarged glands due to chronic suppuration."

In April, 1914, a school dentist and an additional nurse, was appointed but actual treatment could not commence until August when the dental clinic was equipped. The following figures show the rapid growth of this service.

	1914.	1916.	1918.	1920.	1930.	1940.	1950.
Number of children treated	472	1,192	2,135	3,954	8,420	5,410	6,223
„ „ dental extractions ...	589	1,584	2,438	5,729	17,115	9,309	8,941
„ „ „ dressings	23	73	93	88	638	1,224	1,506
„ „ „ fillings	655	1,282	960	2,485	4,899	3,237	3,230
„ „ „ scalings	—	67	147	446	708	536	232

This remarkable increase in numbers revealed the fact that the parents appreciated the work done at the clinic, and also that the children were not afraid to have the offending teeth removed. Very few failed to keep appointments, and there were 1,161 "casual" attendances of children who came for treatment without first being invited.

The work of the school dentist in the clinic was greatly facilitated in 1919 by the installation of an electrically-driven dental engine to replace the treadle-machine.

A second school dentist, commenced duty early in 1920, enabling additional school dental inspection to take place. During this year the teeth of 5,985 children were inspected.

In 1944 a long-felt need was met when a Consultant Orthodontist was appointed. Although only in an improvised work-room he was able to undertake almost all types of cases using the latest forms of stainless steel apparatus. The rare cases involving extensive surgical treatment were sent by appointment to the Manchester Dental Hospital.

There were 225 visits made by children in 1950 to the Orthodontist and 54 appliances were fitted.

Dental treatment sessions are now held at Regent Road, Police Street, Encombe Place and Murray Street Clinics, which render service, not only to school children but to pre-school children, and expectant mothers referred from the maternity and child welfare centres.

SPEECH THERAPY.

The early reports of the School Medical Officer show that around 1908-1912 stammering was fairly common, more especially among boys than girls. An average of 1·5% among 12-year-old boys was shown. Teachers were encouraged especially in infants' departments to pay increased attention to elocution and breathing : swimming was also encouraged with apparently good results.

About 1926 a special class for stammerers was operating at St. Ambrose School and, up to 1931, 41 pupils (30 boys and 11 girls) were discharged and kept under observation. Of these twelve were completely cured, others showed marked improvement, and only two showed no permanent benefit.

During 1944 Speech Clinics were held in three Salford schools, each clinic being visited twice a week by the speech therapists. A hundred and three children were under treatment during the year, but there was still a waiting list of 123 and cases were put under treatment in order of severity or likelihood of responding to treatment. In other cases advice was given to parents on how best to help the children to overcome their difficulties.

In 1945 a new Speech Clinic was opened to centralise treatment, and questionnaires to head-teachers disclosed that roughly 2% of the school population, which was the figure expected, were estimated to have defective speech.

MINOR AILMENTS CLINICS.

It is a far cry to the days of inadequate treatment before our first clinics opened, but today the Minor Ailments Clinic has inspired such confidence in the children that they look forward to attending. Our Regent Road Centre opened in 1912 to replace the clinic at the Education Offices. Present-day treatments total around 80,000 annually at our many centres.

EYE CLINIC.

Special attention has been given to the question of children's eyesight under the supervision of the School Medical Officer.

In 1904 teachers were instructed on how to perform the initial sight test and, where the result was below a certain standard, the parents were advised to consult a medical practitioner, or to bring the child to the Committee's Medical Officer. If glasses were required these could be obtained for 3s. 6d. a pair, payable weekly if the parents so desired.

The pressure of work became so intense that the School Medical Officer could not devote sufficient time to eyesight and a qualified practitioner was appointed for two half-days per week. Dr. McNab commenced duty in September, 1908.

A system of recording vision tests by age groups was instituted in 1909. In 1913 a full-time assistant medical officer with special qualification for dealing with the eyesight of children was appointed.

During World War I, there was a serious curtailment of progress in all departments, but immediately following this clinic a more comprehensive system of sight-testing was evolved.

Dr. Dorothy Simmons was appointed in 1927 and all external eye diseases were referred to her weekly clinic at Regent Road. It was set up in September, 1927, and at the end of that year cases examined and treated numbered 359.

A full-time Orthoptic Clinic was opened in August, 1938.

The scope of this branch of the School Health Service has been greatly increased in recent years and in 1950 there were 2,130 cases of refraction, involving the prescription and supply of 1,223 pairs of glasses.

Two thousand five hundred and nine children attended for Orthoptic occlusion and routine inspection, and 305 required treatment. Forty-eight squint operations were performed. Artificial eyes are now supplied free of charge.

External eye diseases, more prevalent in spring and autumn, vary in number considerably. Blepharitis, conjunctivitis and corneal ulcers are not frequent due to continuous treatment with modern medicine, and the improved health of the Salford school child.

ADVANCEMENTS IN THE TREATMENT OF RINGWORM.

There was a time when the treatment of ringworm was taken in hand by the local chemist or barber, inexpertly dealt with at home, or abandoned completely because of the necessity for lengthy attention.

According to Sabouraud the average time for cure was 27 months, but even when parents were doing their utmost with daily treatment, it was common for cases to persist for two or three years or more. Parents became discouraged or could not afford to continue paying the private doctor, so treatment lapsed. There was a tendency among doctors to pronounce cases cured before they actually were, and there was friction with the parents when the Medical Officer refused to re-admit a child to school because it still had fungus-infected patches in the scalp. Regular checks on progress and treatment were then enforced.

During 1909 school nurses concentrated on the treatment of ringworm and it was proposed that X-rays should be used. The Board of Education agreed on condition that—

- (1) 2s. 6d. per case was contributed ;
- (2) treatment was given only by skilled operators ;
- (3) that a room be specially set aside for this purpose ;
- (4) that the local Education Authority ensured that no child with ringworm be allowed to attend school ;
- (5) cases were treated only on authority, and under supervision, of the School Medical Officer.

Of 500 cases of ringworm of the scalp in 1910, 58 were treated at the Central Office, and 36 were cured in an average of four and a half months (compared with the $2\frac{1}{2}$ to 3 years treatment with ointments). Even this was considered unsatisfactory, due to the fact that X-ray power was supplied from storage batteries only, and in 1911 this method of treatment was entirely suspended pending better equipment and increases in the medical staff.

The high incidence of ringworm, before the effective use of X-ray methods, is shown in school medical service reports. In 1909 there were 111 cases of ringworm of the scalp ; in 1910 there were 500 cases, and in 1911 716, with 241 cases of body ringworm.

Authority was received in 1912 for X-ray apparatus to be installed. This apparatus was done in April, 1913, and cases were treated by epilation of the scalp, either whole or in part. An assistant medical officer and a nurse undertook special training in this work at a London hospital.

From this time onward the incidence of this disease rapidly declined and children who previously had the disease for 18 months returned to school, cured, five weeks after application of the rays.

We find that in 1921 the charge for treatment by X-ray was doubled—from 2s. 6d. to 5s. 6d.—but the rapidity of complete cure fully compensates for this.

Today the diagnosis of ringworm is aided by use of the Wood's lamp ultra-violet ray and cases requiring epilation are referred to the Manchester Skin Hospital for treatment.

It seems too much to hope that this disease will be completely eradicated, but there is definite indication that very soon the number of cases will be negligible. Even now the presentation of a case of ringworm is an exception rather than the rule.

GREENGATE HOSPITAL AND OPEN-AIR SCHOOL. (From information supplied by Mrs. C. U. Frankenburg).

When Dr. Grimke began his pioneer work on rickets in Salford in 1872 he laid the foundations of great work which has continued ever since at the Greengate Hospital and Open-air School, not only for children with rickets—which is practically non-existent today—but for the not-so-healthy children in need of proper care and attention.

Every Sunday evening weakling children come into “ Greengate ”—which is far from green in its surroundings, nestling as it does, in one of the grimmest industrial parts of the City—and leave again for their homes on Friday. Their only treatment is adequate rest, good food, exercise and happiness. The results in the improved health of the little patients during the past 50 years or so are a striking testimony to its value, and the strides forward in the care of these weaker children indicate the great progress made in the health services for school children.

In 1876 Dr. Grimke opened his Salford Medical Mission—in the same old buildings he had bought in Greengate—and began his pioneer work on rickets, twisted limbs of Salford children, a work which was later continued, and expanded, by Dr. Mumford. When Dr. Grimke died in 1877, Mrs. Grimke was persuaded by Sir William Mather to share her building with the Salford Day Nursery (opened in 1883). She handed over the entire building to trustees, but continued to defray the Salford Medical Mission expenses entirely out of her own pocket. The “ Greengate Hospital and Open-air School ” came into being, as such, in 1902, and on the death of Mrs. Grimke, it seemed it must

close. The attending physicians appealed to Sir William Mather for assistance. He promised £100 a year for five years if the physician would gather sufficient friends together to place it on a permanent public basis. After five years Sir William was satisfied with the success and continued to subscribe to its support.

“ Had it not been for his support,” said Dr. Mumford, “ the Institute would have long since been given up instead of increasing its activity year by year.” He took a great interest in the hospital for many years and made its reputation for the cure of rickets.

“ Greengate believes so strongly in family life that some 30 years ago, when they were offered a large Government grant, on condition that they removed to the country, they refused it, preferring not to separate the children from their homes, but to ‘ educate ’ the parents by proving that they could be cured in the next street without the magical ‘ country air ’ ! ”

The hospital was recognised by the Board of Education as a Special School in 1903 ; the first trained teacher was appointed in 1905 and the first trained matron in 1909. In 1917 the Dispensary and Day Nursery Committees amalgamated, and Matron Gentles—who stayed until July, 1942—was appointed. It was in 1919 that the late Dr. Montessori visited Salford to see this hospital and Nursery School—the first Nursery School to be registered in Great Britain. Four years later a building in Back Hampson Street was used for a school, and in 1924 it began admitting children much younger—saving deformities which took so long to correct. The local public health authority asked for admission of $2\frac{1}{2}$ -year-olds to 4-year-olds.

Because it is also a school, Greengate Hospital was not taken over by the State in 1948, yet its 40 beds are always full and there is a long waiting list.

The children are always made to feel that they “ belong ” to somebody. They are cared for in groups, each group under its own particular nurse.

Parents are asked to contribute 5s. 0d. per week mainly to make them realise the hospital is their own. Most of the hospital’s funds come from public charity. Two of the poorer streets once decorated their houses and pavements and collected £30 for “ our hospital,” and a local darts team sends its regular contribution.

In “ The Nursery World ” of April, 1950, Mrs. C. U. Frankenburg quotes from a report of two Ministry of Education inspectors : “ There was an obvious feeling of security and a sense of ownership of the place—a first rate relationship between children and staff—the best group of children seen since the war.”

Mrs. Frankenburg tells of an American officer who, during the last war, came to inspect her home—where the hospital lived at the time—with a view to commandeering it for his men. He saw the children, heard a little about them and exclaimed : “ I would as soon think of commandeering Buckingham Palace ! ”

TRENDS IN MORTALITY AND CAUSES OF DEATH OF CHILDREN, AGED 5 TO 15 YEARS, FROM 1901 TO 1950.

During the past 50 years the mortality rate of the 5 to 15 age group of the population has decreased from 4·6 per 1,000 to 0·5 per 1,000.

CAUSES OF DEATH.

The maximum number of deaths from enteric fever during the past 50 years was eight out of 46,863 (5-15 population) in 1901. The last death was in 1927. The number of deaths through measles was consistent up to 1936, with a maximum of 11 deaths out of 44,000 in 1916. There have been two deaths during the last ten years.

There were many deaths from scarlet fever up to the middle 1920s—24 in 47,876 in 1914—but they have tailed off, and no cases of death have been reported since 1940. The danger of death from whooping cough has now disappeared. Diphtheria, which took a very heavy toll—45 out of 46,863 in 1901—caused the death of only two children in 1946 and none since.

Deaths from influenza were few and sporadic until 1918. There were 55 deaths between 1919 and 1923. There was a sharp drop to four, and since 1943 no deaths have occurred.

Deaths from tuberculosis of the respiratory system were very prevalent up to 1923, there being 28 in 1916. Five children died in 1942, but there have been no deaths since 1946. The first deaths notified from T.B. Meningitis were in 1911, and the maximum number was in 1918 when there were 23. There were only three in 1946, and over the last ten years the highest number has been five.

Since 1911 and up to 1936, deaths from rheumatic fever have averaged three per year. In the last ten years there have been five deaths. Since 1918, when there were nine deaths from meningitis, fatalities from this disease dropped and disappeared from 1938 to 1945, when there was one death. There has been none since 1948. Deaths from cerebro-spinal fever were first reported in 1912, with a maximum of four in 1916, but they disappeared in 1942.

Heart disease was a consistent cause of death up to 1946, with a maximum of 16 deaths in 1905. This figure gradually declined, and over the last ten years there have been 20. Deaths from bronchitis have slowly declined since 1929 (when there were five) and in 1949 there was only one.

Deaths from pneumonia—a major cause of death up to 1942—showed a rise from 10 to 32 in 1918. There has been a rapid decline since the early 1940s, probably due to the use of anti-biotics. Deaths from other respiratory diseases have virtually disappeared since 1933 and there have been only three cases during the last ten years.

Deaths from diarrhoea and enteritis were sporadic but fairly common up to 1922. There were six deaths between 1929 and 1933 and has been none since. Appendicitis deaths first appeared in 1911, but had practically disappeared after 1941. Deaths from other digestive diseases—first recorded in 1932—averaged about three per year up to 1942, and none since 1948.

In 1911, when deaths from nephritis were first noted there were seven out of 49,002. Deaths due to congenital debility have been sporadic and negligible, and there have been five cases in the last ten years.

During the past 50 years no deaths from smallpox have been recorded ; four have been recorded from encephalitis, and two from erysipelas. There have been three deaths from venereal disease, three from poliomyelitis, and only one from diabetes. Cancer deaths have been few and sporadic, the maximum figure being three in 1941. There have been three deaths since then.

Accidents and other cases of violence have been a consistent cause of death in this age group—5 to 15—and the proportion of deaths from this cause has greatly increased since the 1920s. In 1901 there were 18 deaths out of a 5-15 population of 46,863, and in 1949 there were five deaths out of 24,320.

Deaths from other defined diseases first became prominent in 1911. The figure of 31 out of 49,002 population continued steadily until the early 1930s, and has then declined to date. The number of deaths from undefined cases, which was high in 1901 (41 per 46,863) fell rapidly from 1910 and virtually disappeared except for three cases after 1921.

Deaths from brain and nervous diseases were first recorded in 1907, when there were 12. They disappeared in 1910, but reappeared in 1941, and in the last ten years 16 deaths have occurred.

Conclusions which may be drawn from these statistics are (1) that zynotics are no longer causes of death in this age group ; (2) that fatal respiratory tuberculosis seems to have disappeared, but deaths occur from other tubercular diseases ; (3) that defined diseases are the most consistent killers ; (4) that brain and nervous diseases are still a cause of death ; (5) accidents have always taken a steady toll, and the proportion of total deaths from this cause in this age group has risen considerably in the last 50 years, particularly from 1921 onwards.

It is a pleasure to record appreciation of the consideration which has been given by you, Mr. Chairman, Ladies and Gentlemen.

This, then, is the report which I now submit. Any suggestions for improvements to our work, or criticisms of it, are always welcome.

I have the honour to be,

Your obedient Servant,

J. L. Brown

School Medical Officer.

